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FRAMEWORK FOR ANNUAL REPORT OF STATE CHILDREN'S HEALTH INSURANCE PLANS UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

Preamble

Section 2108(a) of the Act provides that the State must assess the operation of the State child health plan in each fiscal year, and report to the Secretary, by January 1 following the end of the fiscal year, on the results of the assessment. In addition, this section of the Act provides that the State must assess the progress made in reducing the number of uncovered, low-income children.

To assist states in complying with the statute, the National Academy for State Health Policy (NASHP), with funding from the David and Lucile Packard Foundation, has coordinated an effort with states to develop a framework for the Title XXI annual reports.

The framework is designed to:

- Recognize the ***diversity*** of State approaches to SCHIP and allow States ***flexibility*** to highlight key accomplishments and progress of their SCHIP programs, **AND**

- Provide ***consistency*** across States in the structure, content, and format of the report, **AND**

- Build on data ***already collected*** by HCFA quarterly enrollment and expenditure reports, **AND**

- Enhance ***accessibility*** of information to stakeholders on the achievements under Title XXI.

FRAMEWORK FOR ANNUAL REPORT
OF STATE CHILDREN'S HEALTH INSURANCE PLANS
UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

State/Territory: Rhode Island
(Name of State/Territory)

The following Annual Report is submitted in compliance with Title XXI of the Social Security Act (Section 2108(a)).

_____
(Signature of Agency Head)

SCHIP Program Name (s) RIte Care

SCHIP Program Type _X_ Medicaid SCHIP Expansion Only
____ Separate SCHIP Program Only
____ Combination of the above

Reporting Period **Federal Fiscal Year 2000 (10/1/99-9/30/00)**

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Submission Date December 31, 2000

SECTION 1. DESCRIPTION OF PROGRAM CHANGES AND PROGRESS

This section has been designed to allow you to report on your SCHIP program? s changes and progress during Federal fiscal year 2000 (September 30, 1999 to October 1, 2000).

1.1 Please explain changes your State has made in your SCHIP program since September 30, 1999 in the following areas and explain the reason(s) the changes were implemented.

Note: If no new policies or procedures have been implemented since September 30, 1999, please enter ?NC? for no change. If you explored the possibility of changing/implementing a new or different policy or procedure but did not, please explain the reason(s) for that decision as well.

A. Program eligibility — NC

B. Enrollment process — NC

C. Presumptive eligibility — Not applicable

D. Continuous eligibility — NC

E. Outreach/marketing campaigns — See Section 2.4

F. Eligibility determination process — NC

G. Eligibility redetermination process — NC

H. Benefit structure — NC

I. Cost-sharing policies — NC

J. Crowd-out policies — NC

K. Delivery system — One health plan, Harvard Pilgrim Health Care of New England, ceased operations in the State of Rhode Island.

L. Coordination with other programs (especially private insurance and Medicaid) — NC

M. Screen and enroll process — NC

N. Application — NC

O. Other — Not applicable

1.2 Please report how much progress has been made during FFY 2000 in reducing the number of uncovered, low-income children.

A. Please report the changes that have occurred to the number or rate of uninsured, low-income children in your State during FFY 2000. Describe the data source and method used to derive this information. — According to the Current Population Survey for 1999, Rhode Island had the lowest uninsurance rate in the nation. See Section 2.4 and Table 1.3.

B. How many children have been enrolled in Medicaid as a result of SCHIP outreach activities and enrollment simplification? Describe the data source and method used to derive this information. — See Section 2.4 Final (i.e, at the end of September) enrollment in Medicaid and SCHIP increased from 63,381 to 77,679 between FFY99 and FFY 00, an increase of 14,388 or 23%. SCHIP alone accounted for 4,118 – non SCHIP MA for 10,270. Source: Title XXI enrollment reports.

C. Please present any other evidence of progress toward reducing the number of uninsured, low-income children in your State. — The State has been overly successful, resulting in budget shortfalls. See document referenced in 1.2.A.

D. Has your State changed its baseline of uncovered, low-income children from the number reported in your March 2000 Evaluation?

_X_ No, skip to 1.3

____ Yes, what is the new baseline?

What are the data source(s) and methodology used to make this estimate?

What was the justification for adopting a different methodology?

What is the State's assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)

Had your state not changed its baseline, how much progress would have been made in reducing the number of low-income, uninsured children?

1.3 Complete Table 1.3 to show what progress has been made during FFY 2000 toward achieving your State's strategic objectives and performance goals (as specified in your State Plan).

In Table 1.3, summarize your State's strategic objectives, performance goals, performance

measures and progress towards meeting goals, as specified in your SCHIP State Plan. Be as specific and detailed as possible. Use additional pages as necessary. The table should be completed as follows:

Column 1:	List your State's strategic objectives for your SCHIP program, as specified in your State Plan.
Column 2:	List the performance goals for each strategic objective.
Column 3:	For each performance goal, indicate how performance is being measured, and progress towards meeting the goal. Specify data sources, methodology, and specific measurement approaches (e.g., numerator, denominator). Please attach additional narrative if necessary.

Note: *If no new data are available or no new studies have been conducted since what was reported in the March 2000 Evaluation, please complete columns 1 and 2 and enter 'NC' (for no change) in column 3.*

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
OBJECTIVES RELATED TO REDUCING THE NUMBER OF UNINSURED CHILDREN		
Improve Outreach efforts	Reduce the percentage of uninsured children	Data Sources: Current Population Surveys (CPS) Methodology: Progress Summary: CPS data for 1999 indicate that Rhode Island has the lowest percentage of people who are uninsured in the country — 6.9 percent.
OBJECTIVES RELATED TO SCHIP ENROLLMENT		
		Data Sources: Methodology: Progress Summary:
OBJECTIVES RELATED TO INCREASING MEDICAID ENROLLMENT		
Improve Outreach efforts	Increase the number of Medicaid eligibles enrolling in RIte Care	Data Sources: Internal eligibility and enrollment systems Methodology: Progress Summary: See RIte Care Outreach Report.

OBJECTIVES RELATED TO INCREASING ACCESS TO CARE (USUAL SOURCE OF CARE, UNMET NEED)		
		Data Sources: **See Section 1.7** Methodology: Progress Summary:
OBJECTIVES RELATED TO USE OF PREVENTIVE CARE (IMMUNIZATIONS, WELL-CHILD CARE)		
		Data Sources: **See Section 1.7** Methodology: Progress Summary:
OTHER OBJECTIVES		
		Data Sources: Methodology: Progress Summary:

1.4 If any performance goals have not been met, indicate the barriers or constraints to meeting them.

1.5 Discuss your State's progress in addressing any specific issues that your State agreed to assess in your State plan that are not included as strategic objectives. Not applicable.

1.6 Discuss future performance measurement activities, including a projection of when additional data are likely to be available. The process is ongoing (see below).

1.7 Please attach any studies, analyses, or other documents addressing outreach, enrollment, access, quality, utilization, costs, satisfaction, or other aspects of your SCHIP program's performance. Please list attachments here.

It is important to understand that the State of Rhode Island does not assess the SCHIP component of RIte Care separately from any other component of RIte Care. For example, the annual member satisfaction survey draws a sample of all persons enrolled in RIte Care. Similarly, the annual calculation of performance measures (administrative, access, and clinical ones as part of the performance incentive system, where participating health plans may earn payments in excess of capitation payments for achievement of performance goals) applies to all populations enrolled in RIte Care. Attached is the SFY 1999 RIte Care Member Satisfaction Survey and data comparing selected HEDIS measures for RIte Care with national Medicaid and commercial benchmarks.

SECTION 2. AREAS OF SPECIAL INTEREST

This section has been designed to allow you to address topics of current interest to stakeholders, including; states, federal officials, and child advocates.

2.1 Family coverage: Not applicable

A. If your State offers family coverage, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other program(s). Include in the narrative information about eligibility, enrollment and redetermination, cost sharing and crowd-out.

B. **How many children and adults were ever enrolled in your SCHIP family coverage program during FFY 2000 (10/1/99 -9/30/00)** (Not Applicable)

Number of adults_____
Number of children_____

C. How do you monitor cost-effectiveness of family coverage?

2.2 Employer-sponsored insurance buy-in: Not applicable

A. If your State has a buy-in program, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other SCHIP program(s).

B. How many children and adults were ever enrolled in your SCHIP ESI buy-in program during FFY 2000?

Number of adults_____
Number of children_____

2.3 Crowd-out:

A. How do you define crowd-out in your SCHIP program?

See Section 1115 Waiver Request of Title XXI and Amendment of Current Title XIX 1115 RIte Care Waiver (Waiver Request).

B. How do you monitor and measure whether crowd-out is occurring?

See Waiver Request.

C. What have been the results of your analyses? Please summarize and attach any available reports or other documentation.

See Waiver Request.

D. Which anti-crowd-out policies have been most effective in discouraging the substitution of public coverage for private coverage in your SCHIP program? Describe the data source and method used to derive this information.

Policies have not been effective. In fact, crowd-out has occurred so that the State submitted Section 1115 waiver or waiver amendment requests to HCFA for both Titles XIX and XXI to stem the crowd-out. The State is planning a February 1, 2001 implementation date for these changes.

2.4 Outreach:

A. What activities have you found most effective in reaching low-income, uninsured children?

The State's primary outreach strategy during this last Federal fiscal year was community-based in approach. We had dedicated, trained outreach staff in health centers, schools, and community-based agencies. In addition to our community-based efforts, we sent information on RIte Care to every elementary school child in the State and broadcast radio ads at the same time.

How have you measured effectiveness?

In the community-based effort, we tracked effectiveness by changes in enrollment. (See attached RIte Care Outreach Report.) Since outreach staff was concentrated in towns/cities with the highest rates of uninsured children, we looked at changes in enrollment by towns/cities, by core cities vs. the rest of the State, and by ethnicity (primarily changes in enrollment of Hispanic children).

B. Have any of the outreach activities been more successful in reaching certain populations (e.g., minorities, immigrants, and children living in rural areas)?

Outreach staff who spoke the primary language of the target audience and helped applicants one-on-one were key in reaching and enrolling Hispanic families. Eighty-eight percent of the outreach staff in the core cities spoke Spanish as well as English.

How have you measured effectiveness?

The number of Spanish-speaking RIte Care enrollees increased 56 percent in the core cities as a result of our outreach activities. (Our estimates at the beginning were that 17,000 Rhode Island children were uninsured.) Current CPS data (1999) indicate that Rhode Island has the lowest percentage of people who are uninsured in the country—6.9%.

In addition, we use the *Insure Kids Now* national Info Line number to track calls to the Info Line s a direct response to the (English) radio ads. The monthly aggregate call data was compiled by HRSA and sent directly to states. Over 500 calls to the (English) Info Line were received as a direct result of the radio campaign.

C. Which methods best reached which populations? How have you measured effectiveness?

Currently, we are working closely with our Covering Kids Rhode Island partners. Their three pilot sites include outreach in schools, outreach to the immigrant population, and outreach in hospitals. We have established strategy codes so that we can measure the effectiveness of different strategies within the three pilot sites. At this time, the results of what works best are not available, but will be very useful in deciding the most effective strategies for future outreach.

2.5 Retention:

A. **What steps is your State taking to ensure that eligible children stay enrolled in Medicaid and SCHIP?** Recertification deadlines have been extended to one year; simplified recertification forms and process have been simplified; eligibility is automatically redetermined after loss of traditional Medical Assistance

B. What special measures are being taken to re-enroll children in SCHIP who disenroll, but are still eligible?

___ Follow-up by caseworkers/outreach workers
_/_ Renewal reminder notices to all families
___ Targeted mailing to selected populations, specify population _____
___ Information campaigns
_/_ Simplification of re-enrollment process, please describe simplified recertification form and verification
_/_ Surveys or focus groups with disenrollees to learn more about reasons for disenrollment, please describe One of RIte Car's contracted health plans has surveyed its disenrolled members and has shared its results with the agency
___ Other, please explain_____

C. Are the same measures being used in Medicaid as well? Yes **If not, please describe the differences.**

D. **Which measures have you found to be most effective at ensuring that eligible children stay**

enrolled? Automatic redetermination after loss of traditional Medical Assistance, extended recertification period

E. What do you know about insurance coverage of those who disenroll or do not re-enroll in SCHIP (e.g., how many obtain other public or private coverage, how many remain uninsured?) Describe the data source and method used to derive this information.

The State has no information in this area.

2.6 Coordination between SCHIP and Medicaid:

A. Do you use common application and redetermination procedures (e.g., the same verification and interview requirements) for Medicaid and SCHIP? Please explain.

Yes, The State uses a common Mail-in application with streamlined verification for those applying solely for Medicaid or SCHIP. More stringent procedures apply to those applying for cash benefits (which also provide Medicaid)

B. Explain how children are transferred between Medicaid and SCHIP when a child? s eligibility status changes.

Not applicable; the State's SCHIP is a Medicaid expansion.

B. Are the same delivery systems (including provider networks) used in Medicaid and SCHIP? Please explain.

Yes, it is one program.

2.7 Cost Sharing:

A. Has your State undertaken any assessment of the effects of premiums/enrollment fees on participation in SCHIP? If so, what have you found?

No

B. Has your State undertaken any assessment of the effects of cost-sharing on utilization of health service under SCHIP? If so, what have you found?

No

2.7 Assessment and Monitoring of Quality of Care:

A. What information is currently available on the quality of care received by SCHIP

enrollees? Please summarize results.

See Section 1.7.

B. What processes are you using to monitor and assess quality of care received by SCHIP enrollees, particularly with respect to well-baby care, well-child care, immunizations, mental health, substance abuse counseling and treatment, and dental and vision care?

See Section 1.7.

C. What plans does your SCHIP program have for future monitoring/assessment of quality of care received by SCHIP enrollees? When will data be available?

Monitoring and assessment of quality of care received by enrollees in RIte Care is a continuous process.

SECTION 3. SUCCESSES AND BARRIERS

This section has been designed to allow you to report on successes in program design, planning, and implementation of your State plan, to identify barriers to program development and implementation, and to describe your approach to overcoming these barriers.

3.1 Please highlight successes and barriers you encountered during FFY 2000 in the following areas. Please report the approaches used to overcome barriers. Be as detailed and specific as possible.

Note: If there is nothing to highlight as a success or barrier, Please enter ?NA? for not applicable.

A. Eligibility — NA

B. Outreach — See Section 2.4

C. Enrollment — NA

D. Retention/disenrollment — NA

E. Benefit structure — NA

F. Cost-sharing — NA

G. Delivery systems —

H. Coordination with other programs — See Section 2.4

I. Crowd-out — See Section 2.3.D and Waiver Request

J. **Other** — NA

SECTION 4. PROGRAM FINANCING

This section has been designed to collect program costs and anticipated expenditures.

4.1 Please complete Table 4.1 to provide your budget for FFY 2000, your current fiscal year budget, and FFY 2002 projected budget. Please describe in narrative any details of your planned use of funds.

Note: Federal Fiscal Year 2000 starts 10/1/99 and ends 9/30/00.

	Federal Fiscal Year 2000 costs	Federal Fiscal Year 2001	Federal Fiscal Year 2002
Benefit Costs			
Insurance payments			
Managed care			
per member/per month rate X # of eligibles	7,972,648	9,000,000	9,562,500
Fee for Service	1,304,509	900,000	956,250
Total Benefit Costs	**9,277,157**	**9,900,000**	**10,518,750**
(Offsetting beneficiary cost sharing payments)	(278,315)	(297,000)	(315,563)
Net Benefit Costs	**8,998,842**	**9,603,000**	**10,203,188**
Administration Costs			
Personnel			
General administration			
Contractors/Brokers (e.g., enrollment contractors)			
Claims Processing			
Outreach/marketing costs			
Other			
Total Administration Costs			
10% Administrative Cost Ceiling	999,871	1,067,000	1,133,688
Federal Share (multiplied by enhanced FMAP rate)	6,764,130	7,218,255	7,669,396
State Share	3,234,584	3,451,745	3,667,479
TOTAL PROGRAM COSTS	**9,998,714**	**10,670,000**	**11,336,875**

Note: Federal Fiscal Year (FFY) 2000 is October 1, 1999 through September 30, 2000.

4.2 Please identify the total State expenditures for family coverage during Federal fiscal year 2000.

Not applicable.

4.3 What were the non-Federal sources of funds spent on your CHIP program during FFY 2000?

_X_ State appropriations
____ County/local funds
____ Employer contributions
____ Foundation grants
____ Private donations (such as United Way, sponsorship)
____ Other (specify) _____

A. Do you anticipate any changes in the sources of the non-Federal share of plan expenditures.

No; it will remain State appropriations.

SECTION 5: SCHIP PROGRAM AT-A-GLANCE

This section has been designed to give the reader of your annual report some context and a quick glimpse of your SCHIP program.

5.1 To provide a summary at-a-glance of your SCHIP program characteristics, please provide the following information. If you do not have a particular policy in place and would like to explain why, please do. (Please report on initial application process/rules.)

Table 5.1	Medicaid Expansion SCHIP program	Separate SCHIP program
Program Name	RIte Care	
Provides presumptive eligibility for children	__X__ No _____ Yes, for whom and how long?	_____ No _____ Yes, for whom and how long?
Provides retroactive eligibility	_____ No __X__ Yes, for whom and how long? For all eligibles up to three months	_____ No _____ Yes, for whom and how long?
Makes eligibility determination	__X__ State Medicaid eligibility staff _____ Contractor _____ Community-based organizations _____ Insurance agents _____ MCO staff _____ Other *(specify)* _____	_____ State Medicaid eligibility staff _____ Contractor _____ Community-based organizations _____ Insurance agents _____ MCO staff _____ Other *(specify)* _____
Average length of stay on program	Specify months _ The State does not have information available on this measure	Specify months _____
Has joint application for Medicaid and SCHIP	_____ No __X__ Yes	_____ No _____ Yes
Has a mail-in application	_____ No __X__ Yes	_____ No _____ Yes

Can apply for program over phone	__X__No _____Yes	_____No _____Yes
Can apply for program over Internet	__X__No _____Yes	_____No _____Yes
Requires face-to-face interview during initial application	__X__No _____Yes	_____No _____Yes
Requires child to be uninsured for a minimum amount of time prior to enrollment	__X__No _____Yes, specify number of months _____ What exemptions do you provide?	_____No _____Yes, specify number of months _____ What exemptions do you provide?
Provides period of continuous coverage <u>regardless of income changes</u>	__X__No * ____ Yes, specify number of months Explain circumstances when a child would lose eligibility during the time period	_____No _____Yes, specify number of months _____ Explain circumstances when a child would lose eligibility during the time period
Imposes premiums or enrollment fees	_____No __X__Yes, how much? _**_____ Who Can Pay? ___ Employer ___ Family ___ Absent parent ___ Private donations/sponsorship _X_ Other (specify) <u>Not specified who can pay</u>	_____No _____Yes, how much? _____ Who Can Pay? ___ Employer ___ Family ___ Absent parent ___ Private donations/sponsorship ___ Other (specify) _____
Imposes copayments or coinsurance	_____No __X__Yes	_____No _____Yes

*No – exception initial 6 month enrollment guarantee. The State uses a12 month recertification interval , but income changes, when reported can remove eligibility. (Note since the State's income cap is 250% of FPL, this does not occur often)

**Those with family income >185% FPL are subject to cost-sharing – either 3% of premium cost (between $2 and $8, depending on age and gender) or copays ($2 for prescriptions Rx, $5 office visits, $15 for ambulatory surgery, $25 for inpatient stays, plus copays for non-authorized use of emergency services.

Provides preprinted redetermination process	__X__ No _____ Yes, we send out form to family with their information precompleted and: ___ ask for a signed confirmation that information is still correct ___ do not request response unless income or other circumstances have changed	_____ No _____ Yes, we send out form to family with their information and: ___ ask for a signed confirmation that information is still correct ___ do not request response unless income or other circumstances have changed

5.2 Please explain how the redetermination process differs from the initial application process.

SECTION 6: INCOME ELIGIBILITY

This section is designed to capture income eligibility information for your SCHIP program.

6.1 As of September 30, 2000, what was the income standard or threshold, as a percentage of the Federal poverty level, for countable income for each group? If the threshold varies by the child**?**s age (or date of birth), then report each threshold for each age group separately. Please report the threshold after application of income disregards.

Title XIX Child Poverty-related Groups or* Section 1931-whichever category is higher	_250% of FPL for children under age __8____
	_100% of FPL for children aged _____8 - 17_
	categorically nearly std_% of FPL for children aged 17 through 18
Medicaid SCHIP Expansion	_250% of FPL for children aged _8 through 18
	____% of FPL for children aged _____
	____% of FPL for children aged _____
State-Designed SCHIP Program	____% of FPL for children aged _____
	____% of FPL for children aged _____
	____% of FPL for children aged _____

*Includes 1115 Waiver prior to SCHIP

6.2 As of September 30, 2000, what types and *amounts* of disregards and deductions does each program use to arrive at total countable income? *Please indicate the amount of disregard or deduction used when determining eligibility for each program. If not applicable, enter ?NA.?*

Do rules differ for applicants and recipients (or between initial enrollment and redetermination) ____ Yes _X_ No
If yes, please report rules for applicants (initial enrollment). JA

Table 6.2

	Title XIX Child Poverty-related Groups	Medicaid SCHIP Expansion	State-designed SCHIP Program
Earnings	$90	$90	$
Self-employment expenses	$ Some	$ Some	$
Alimony payments Received	$	$	$
Paid	$	$	$
Child support payments Received	$50	$50	$
Paid	$	$	$
Child care expenses	$175 (200 if <age 1)	$175 (200 if age 1)	$
Medical care expenses	$	$	$
Gifts	$	$	$
Other types of disregards/deductions (specify)	$	$	$

6.3 For each program, do you use an asset test?

Title XIX Poverty-related Groups	__X__ No	____Yes, specify countable or allowable level of asset test_____
Medicaid SCHIP Expansion program	__X__ No	____Yes, specify countable or allowable level of asset test_____
State-Designed SCHIP program	_____No	____Yes, specify countable or allowable level of asset test_____
Other SCHIP program_____	_____No	____Yes, specify countable or allowable level of asset test_____

6.4 Have any of the eligibility rules changed since September 30, 2000? ___ Yes __X__ No

But they will, effective February 1, 2001.

Changes pending HCFA approval*

Affordability - if eligible for employer sponsored insurance costing less than affordability limits ($150/Individual $300/family) new applicant not eligible until 6 months have passed without coverage.

Cost-Sharing – at 150% FPL+, except infants and pregnant /post partum women (higher levels apply for these groups.
No retroactive eligible prior to 1st day of the month of application.

*These changes would apply to those not eligible under traditional Title XIX Medicaid

SECTION 7: FUTURE PROGRAM CHANGES

This section has been designed to allow you to share recent or anticipated changes in your SCHIP program.

7.1 What changes have you made or are planning to make in your SCHIP program during FFY 2001(10/1/00 through 9/30/01)? Please explain why the changes are planned.

A. Family coverage — See Waiver Request, page 3, paragraph 2 and 3 and page 27, first bullet.

B. Employer sponsored insurance buy-in — See Waiver Request, pages 11 and 35.

C. 1115 waiver — See Waiver Request pages 27 and 28.

D. Eligibility including presumptive and continuous eligibility — The State will maintain the current 12-month continuous eligibility rule.

E. Outreach — The Department of Human Services currently funds a Family Resource Counselor Program as a Medicaid outstationing requirement. Over 30 Family Resource Counselors are employed by 13 State-wide health centers and four community hospitals to provide assistance to potential Medicaid applicants. Also, see Section 2.4.

F. Enrollment/redetermination process — Rhode Island uses an English/Spanish joint simplified mail-in application for SCHIP and Medicaid with limited verifications of income, proof of pregnancy, and immigration status required**.** Rhode Island also uses a mail-in recertification application to recertify continued eligibility on an annual basis. The Department of Human Services is currently changing the recertification application to a computer-generated renewal form to simplify the process. The recipient's information will be mailed on a pre-printed form with a self-addressed, stamped envelope.

G. Contracting — NA

H. Other — See Waiver Request, regarding crowd-out.

RIte Care Outreach Report

October 2000

Center for Child and Family Health

Final Version 11/17/00 National Academy for State Health Policy

600 New London Avenue
Cranston, Rhode Island 02920

ACKNOWLEDGMENTS

RIte Care, Rhode Island's Medicaid/SCHIP Program, provides health coverage for eligible uninsured low-income children up to age 19.

In 1998, the RI Department of Human Services, along with other states in the nation, made a commitment to find and enroll children who didn't have health insurance, primarily to assure access to needed health care services. At the time, there were an estimated 17,000 children in Rhode Island who were without health coverage.

This report is a testament to the efforts of many community agencies, individuals, and other state agencies to meet this challenge. Our success can be attributed to the dedicated outreach workers, family resource counselors and others who enrolled families and children in RIte Care. Many thanks for your commitment and time to this cause.

The following partner organizations have also contributed greatly to the planning and implementation of this Outreach Project. Without their input and advise, DHS could not have enrolled as many children and parents. They include:

Rhode Island Kids Count
Covering Kids Rhode Island
RI Health Center Association
Ocean State Action
The RI Department of Health
The RI Department of Education

Christine C. Ferguson
Director
RI Department of Human Services

Background

In 1998, the Department of Human Services (DHS) initiated an aggressive statewide Outreach Project to enroll eligible children and families into RIte Care, Rhode Island's Medicaid/SCHIP Program. The goals of the project included enrolling all eligible uninsured children, simplifying the enrollment process and decreasing barriers to enrollment. At the time, it was estimated that 17,000 children in the state were uninsured. Data from the Department of Human Services, RI Kids Count and other sources indicated that almost 60% of the uninsured children lived in four cities- Providence, Pawtucket, Central Falls and Woonsocket. It was also known that Latino and immigrant families were more likely to be uninsured. Based on this information, resources were targeted to four "core" cities with the highest number of uninsured children with some outreach capacity outside the core areas.

At the same time, national attention was focused on outreach to enroll uninsured children. In 1997, Congress created the State Children's Health Insurance Program (SCHIP) to enable states to enroll 11 million children nationwide that were uninsured. In Rhode Island, the SCHIP program was combined with the Medicaid managed care program- RIte Care.

In November 1999, the Robert Wood Johnson Foundation funded a national three-year project called Covering Kids that assists states in enrolling uninsured children. Rhode Island's grantee is RI Kids Count. Covering Kids Rhode Island will focus on three specific strategies- outreach at health care organizations in Providence, school-based outreach in Pawtucket and outreach to Latino and other immigrants in Central Falls. Covering Kids Rhode Island will assist the state to document outreach strategies that work and reduce barriers to enrollment.

Several state agencies and community organizations worked collaboratively with the Department of Human Services to design and implement this Outreach Program. These include: the RI Department of Education, the RI Health Center Association, RI Kids Count, Ocean State Action, and the Rhode Island Department of Health. Without these partnerships, the Outreach Program would not have been as successful in reaching its goals.

Goals of the Outreach Program

- To enroll all eligible Rhode Island children in the RIte Care Program
- To streamline the application and eligibility processes
- To reduce barriers to enrollment
- To develop a training component to the Outreach Program
- To target outreach to Latino and other non-English speaking populations
- To use a combination of outreach strategies
- To evaluate and institutionalize effective outreach strategies

RIte Care Outreach

Streamlined Application and Enrollment

Families can now apply for RIte Care health insurance by mail and do not have to come in for an appointment. Verification of documentation needed has also been reduced, making the overall application process easier. In the summer of 1999, the application was translated into Spanish.

Community-based Approach

DHS increased its outreach capacity statewide with a targeted effort in four cities with the highest rates of uninsured children—Providence, Pawtucket, Central Falls and Woonsocket.

In April 1999, 31 community based agencies participated in a statewide outreach program. Thirteen agencies hired 16 full time bilingual outreach staff. These outreach workers worked primarily in the four target communities. Eighteen additional agencies used existing staff to enroll potential applicants. These agencies were outside of the 4 target communities.

Strategies that were used include:

- Word of mouth
- Contacting families through other programs at community agencies
- Distributing posters and flyers on RIte Care in the community
- Traditional door to door outreach
- School-based strategies
- Radio

DHS also provided funding, along with the Department of Health, for the Family Resource Counselors Program (FRC) at 14 Community Health Centers and 3 Hospitals in Rhode Island. This funding made training and on-going support of the FRC and Outreach Programs possible.

School-based Outreach

Several school-based initiatives started this year. They include:

- Using the school lunch application to reach families
- Distributing RIte Care brochures to all RI elementary students
- Developing book covers for all RI middle school students that included RIte Care's toll free numbers on it as well as other health information. This was a joint effort of the Department of Health and the Department of Human Services.
- Enrolling families at Kindergarten registration at all schools in the Pawtucket school system
- Enrolling families at five school-based health centers

Training

A comprehensive RIte Care training manual was developed and distributed to outreach staff, DHS staff and other interested outreach partners. On-going training and support was provided for outreach staff on a regular basis.

Media Campaign

In support of the school based strategies that were happening in the Fall of 1999, radio ads on RIte Care were broadcast on 5 English stations and 1 Hispanic station over a 6 week time period. The Insure Kids Now phone number was used to track the number of calls to the RIte Care Info Line as a direct result of the radio campaign. During the month that the ads ran, there were over 500 calls to the (English) Info Line. Calls to the Spanish Info Line were recorded by a different method. During this time period, calls to the (Spanish) RIte Care Info Line increased by 18 percent.

RESULTS

- From August 31, 1998 to June 30, 2000, RIte Care enrollment increased by 39 percent from 74,948 enrollees to 104,041 enrollees. This represents an increase of 15,364 children.

- 69 percent of the children enrolled were from the core cities and 31 percent were from the rest of the state.

- 88 percent of the outreach staff in the core cities spoke Spanish as well as English.

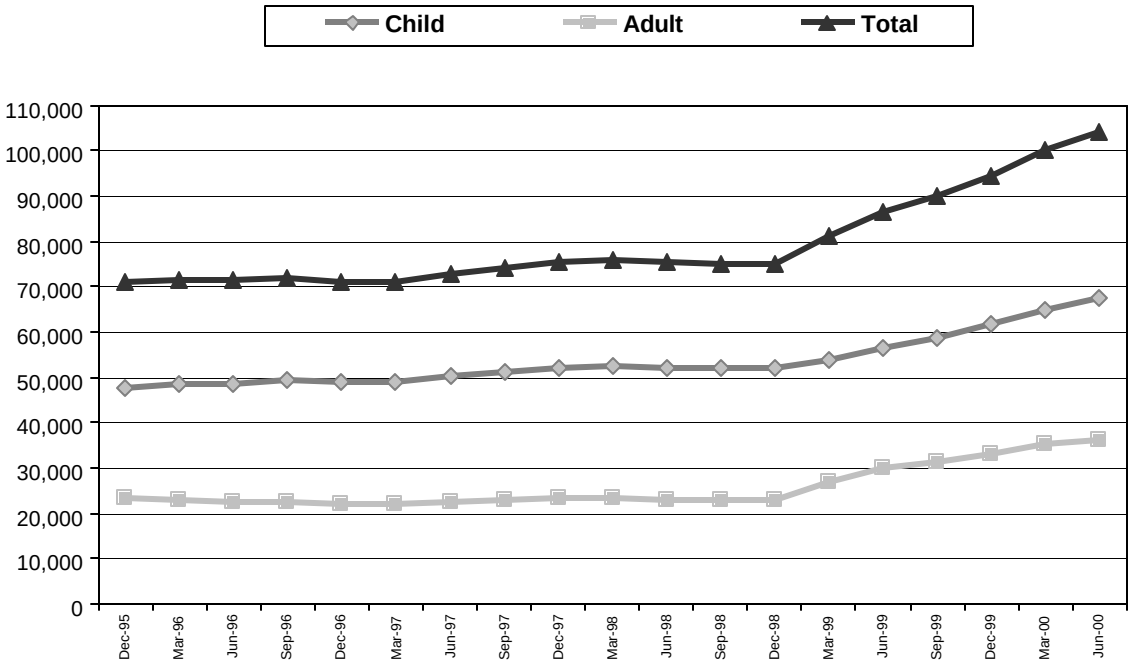
- The number of Spanish speaking RIte Care enrollees increased by 56 percent in the core cities (from 8/31/98 to 6/30/00).

- RIte Care ads were run on a Hispanic radio station in the Fall of 1999. Calls to the Spanish Info Line increased by approximately 18 percent during this time period.

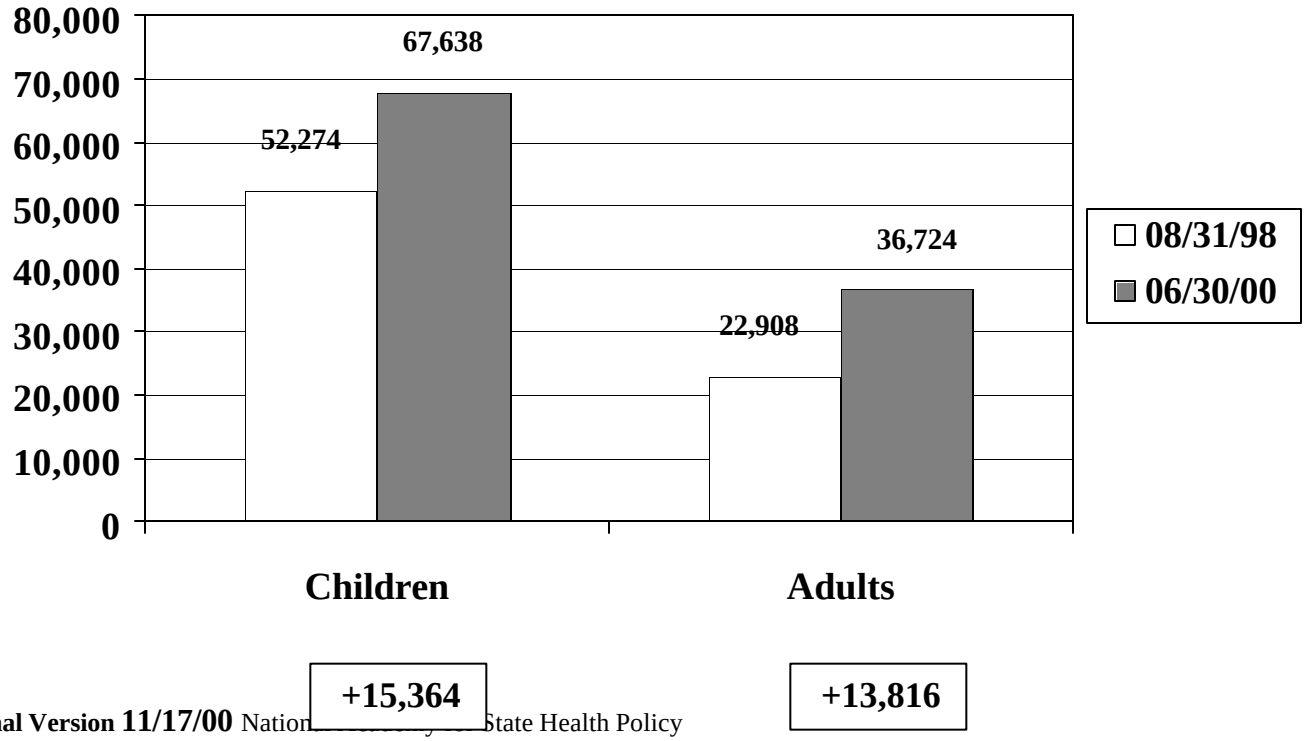
- RIte Care ads were run on 5 English radio stations in the Fall of 1999. The Insure Kids Now phone number was used to track the number of calls to the Info Line as a direct result of this radio campaign. During the months the ads ran, there were over 500 calls to the (English) Info Line.

- A comprehensive RIte Care training manual was developed and distributed to outreach staff, DHS staff and other interested outreach partners. On-going training and support was given to outreach staff on RIte Care.

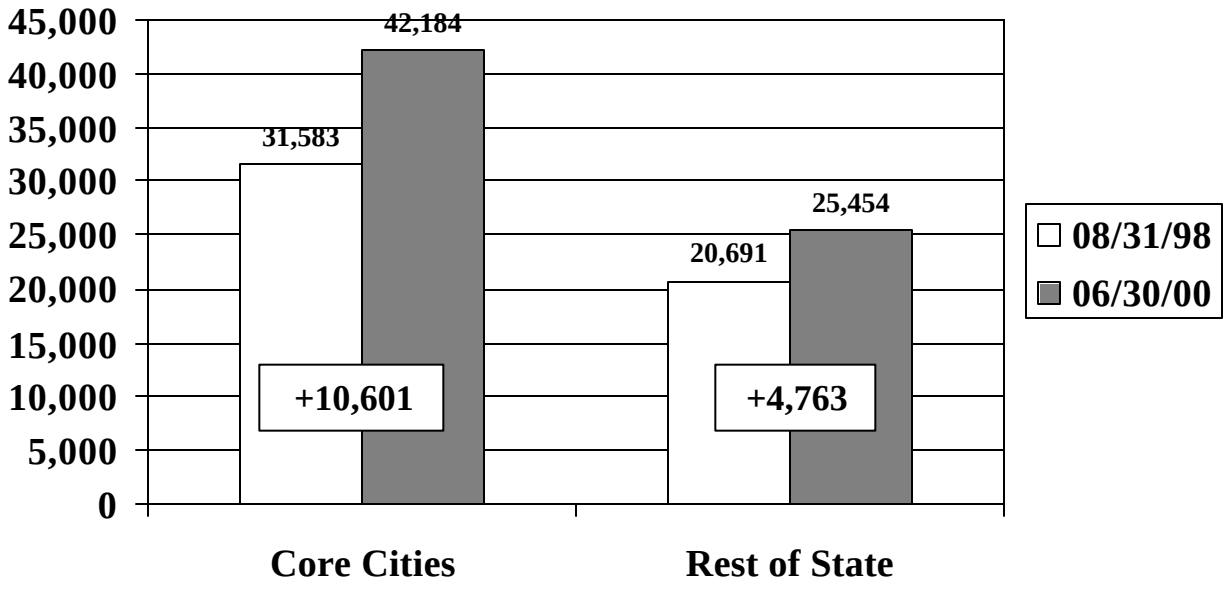
RIte Care Enrollment in Thousands
1996 - 2000



Growth in RIte Care Enrollment
Statewide From 8/31/98 to 6/30/00

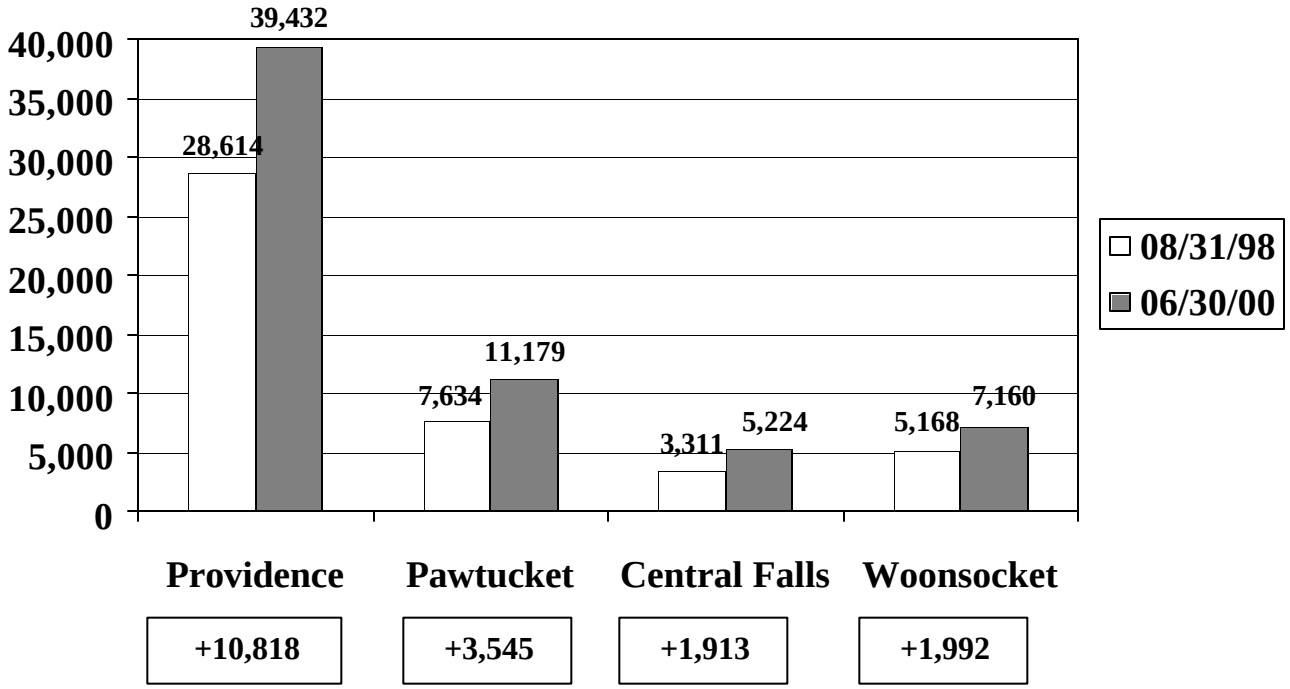


Growth in RIte Care Enrollment
Children

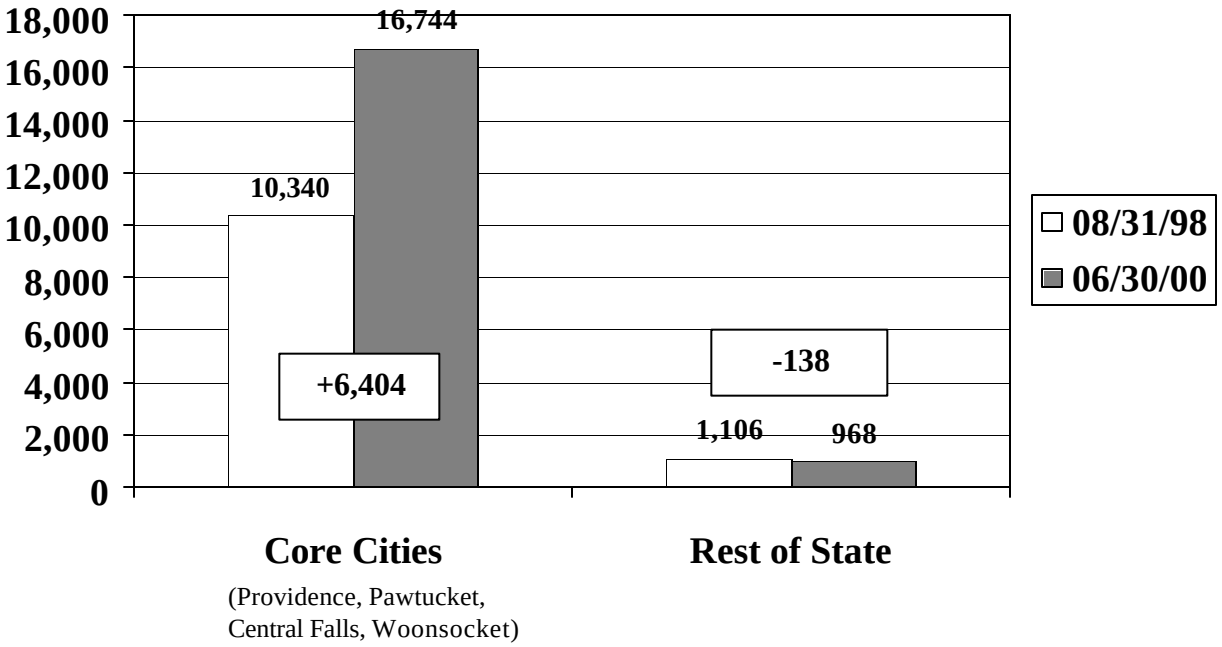


(Providence, Pawtucket,
Central Falls, Woonsocket)

Growth in Enrollment
Core Cities
Adults and Children



Growth in Enrollment
Spanish Speaking Population
Adults and Children



(Providence, Pawtucket,
Central Falls, Woonsocket)

Outreach Agencies Participating in RIte Care Outreach

Option A Agencies

Option A agencies contracted with DHS to hire 1-2 outreach workers per agency to help families enroll in RIte Care.

Progreso Latino
Children's Friend and Service
Capital City Community Centers
Center for Hispanic Policy and Advocacy
Genesis Center and the Family Van
Joslin Community Center
Public Education Fund
Planned Parenthood of Rhode Island
Socio-Economic Development Center
South Providence Neighborhood Ministries
Urban League of Rhode Island
Family Resources
Connecting for Children and Families

Option B Agencies

Option B Agencies contracted with DHS to enroll families in RIte Care using existing agency staff.

Allen Intergenerational Wellness Center
Blackstone Valley Community Action Program
Comprehensive Community Action
Cunningham School COZ
East Providence Boys and Girls Club
Family Services
HELP Lead Safe Center
International Institute of Rhode Island
Newport County Community Mental Health Center
New Visions for Newport County
St. Joseph's Health Services of Rhode Island
Self Help, Inc.
South County Community Action
Travelers Aid Society of Rhode Island
Trinity Encore
Visiting Nurse Association of Care New England
Visiting Nurse Service, Bristol and Newport Counties
Westbay Community Action

Family Resource Counselors Program

Family Resource Counselors at the following health centers and hospitals screen families to determine if they may be eligible for RIte Care. They also help families apply for other public programs.

Allen Berry Health Center
Bayside Family Health Care
Blackstone Valley Community Health
Block Island Health Services
Capitol Hill Health Center
Central Health Center
Central High School
Chad Brown Health Center
Comprehensive Community Action
Dr. John A. Ferris Health Center
Fox Point Health Center
Health Center of South County
Memorial Hospital of Rhode Island
New Vision for Newport County
Northwest Health Center
Olneyville Health Center
St. Joseph's Health Services of RI
Self Help/ East Bay Family Health Center
Thundermist Health Associates
Tri Town Health Center
Women and Infants Hospital
Wood River Health Services

Section 1115 Waiver Request of Title XXI

Amendment of Current Title XIX 1115 RIte Care Waiver

Submitted To:
Division of Integrated Health Systems
Health Care Financing Administration

Submitted By:
Rhode Island Department of Human Services
Center for Child and Family Health

November 2, 2000

EXECUTIVE SUMMARY

The RIte Care program, Rhode Island's Medicaid managed care program, purchases health insurance for approximately 105,000 members, more than three quarters of Rhode Island's Medicaid population and 11 percent of all Rhode Islanders. It is administered by the Center for Child and Family Health within the Rhode Island Department of Human Services. Over the past six years, RIte Care has contributed significantly to reducing the rate of uninsurance in Rhode Island by providing health insurance to low-income children and families throughout the State. Currently, eligible populations include: all uninsured pregnant women with incomes up to 250 percent of the federal poverty level (FPL); uninsured children under age 19 with incomes up to 250 percent of the FPL; and uninsured parents of enrolled children under age 19 with incomes up to 185 percent of the FPL. RIte Care combines Temporary Assistance to Needy Families (TANF) and TANF-related families, Medicaid poverty level, 1115 waiver and 1931 expansions and SCHIP eligible populations in one seamless delivery system.

RIte Care was implemented in 1994 under the authority of an 1115 Research and Demonstration waiver of Title XIX of the Social Security Act. This provided Rhode Island with the means to create a comprehensive, coordinated health care delivery system via competitively procured contracts with licensed health maintenance organizations (HMOs or Health Plans). These contracts have provisions that require participating Health Plans to adhere to specific quality, access and performance standards. As well, the contracts mandate health outcome measures to be reported to the Department, which are subsequently analyzed.

RIte Care has demonstrated excellent member satisfaction, significant improvements in access to health care and health status including, primary, pediatric, and prenatal care, increased inter-birth intervals, decreased maternal smoking, positive trends in addressing the incidence of low-birth weight among RIte Care newborns, and increased childhood immunization and lead screening rates. RIte Care has also been successful in contributing to the significant reduction in Rhode Island's rate of uninsurance to 6.9 percent, the lowest in the nation in 1999.

Rhode Island's primary goals in establishing and expanding eligibility for RIte Care was to increase access to and improve the quality of health care for Medicaid families and to expand access to health coverage for the uninsured. The initial expansion of eligibility under the State's Section 1115 RIte Care waiver was directed at pregnant women and preschool children with family incomes up to 250 percent of the FPL. Since then, the State has used RIte Care as a medium to extend coverage to low-income uninsured families including children to age 19 with family incomes up to 250 percent of the FPL and their parents with incomes up to 185 percent of the FPL.

It is important to note that Rhode Island has long had a strong system of employer-sponsored health insurance (ESI). In seeking to extend eligibility to the uninsured, State policymakers did not intend for RIte Care to serve as a substitute for ESI nor as a competitor to commercial plans. Rather, the intent

was, and continues to be today, to make quality health coverage available to those without access to ESI.

A. RIte Care Extends Eligibility To Low-Income Parents

In 1998, the State of Rhode Island sought to extend eligibility for RIte Care to parents and relative caretakers of children enrolled in RIte Care. The State chose to pursue this course of action for several reasons. First, feedback from RIte Care enrollees underscored the absence of comprehensive coverage for the entire family as a major program weakness, particularly for uninsured parents of enrolled children and women covered under the Extended Family Planning limited benefit package. Second, the number of uninsured Rhode Island adults who were employed was increasing significantly (from 51.5% in 1996 to 69% in 1998) due to the erosion of ESI. Third, the health care research literature offered persuasive evidence indicating even the most ambitious and systematic efforts to promote prevention and other health goals for children and adolescents often fall short when parents and relative caretakers have limited access to health care.

Accordingly, in July 1998, after the enactment of Title XXI of the Social Security Act authorizing the implementation of the State's initial State Child Health Insurance Program Plan (SCHIP), Rhode Island submitted a SCHIP amendment requesting authority to extend coverage to the growing number of uninsured parents. On December 29, 1998, after receiving specific guidance from the Health Care Financing Administration (HCFA), the State voluntarily withdrew the SCHIP amendment request for family coverage and submitted a Medicaid State Plan Amendment to establish a new eligibility group, effective on November 1, 1998, consisting of families with children with incomes under 185 percent of FPL pursuant to Section 1931 of the Social Security Act.

The eligibility expansion under Section 1931, which was implemented in tandem with an extensive outreach endeavor, has proven highly successful in enrolling both eligible children and their parents. Since February 1999, enrollment has increased by almost one-third, from 78,418 to 105,500 (as of October 31, 2000). The magnitude of this change in enrollment has created significant unexpected and unintended consequences - the migration of a significant number of families into RIte Care from ESI and unexpectedly high, unbudgeted increases in program costs to the State.

B. Migration From ESI To RIte Care

During calendar year 1999, the first year period following the Section 1931 expansion to parents, only two Health Plans were accepting RIte Care enrollees: a commercial plan, United HealthCare of New England (UHCNE); and a Medicaid only plan, Neighborhood Health Plan of Rhode Island (NHPRI). Data provided by UHCNE, a Rhode Island health insurance carrier active in the commercial and Medicaid markets, indicated a significant number of RIte Care enrollees migrated to their RIte Care plan from their commercial products.

Further analysis of the UHCNE data revealed that movement from ESI into RIte Care was occurring at a much greater rate in eligible families with incomes below 185 percent of the FPL. Although there are RIte Care eligibility requirements in place designed to discourage substitution of ESI (e.g., four-month waiting period), they do not currently apply to families with incomes below 185 percent of the FPL. In short, less than 18 months after the State's Section 1931 Medicaid expansion, there was reliable evidence indicating that a significant number of eligible families with incomes less than 185 percent of the FPL were dropping ESI to enroll in RIte Care. These families were not subject to provisions that deter substitution since they had incomes below 185 percent of the FPL.

C. Instability In The State's Commercial Health Insurance Market

Some degree of migration is to be expected anytime there is a significant expansion in eligibility for a publicly funded or subsidized program. Both the scope and consequences of the shift from ESI to RIte Care on the part of Section 1931 parents were greater than anticipated, largely because of the unforeseen volatility in the State's private insurance market. In late 1999, the instability in Rhode Island's health insurance market was becoming more apparent. High increases in premium rates during 1999 and 2000 in commercial policy renewal rates affected both employers and employees. The impact on small firms and low-wage workers was particularly pronounced; low-wage workers who were unable to afford higher premium share contributions were driven out of the commercial insurance market and into RIte Care. Since RIte Care does not have provisions to deter substitution for families with incomes below 185 percent of the FPL and there is no waiting period for families who drop affordable ESI immediately prior to applying for RIte Care, there is no disincentive, or cost, for workers opting to shift from ESI to RIte Care.

During the same period that costs of commercial insurance began to escalate, the number of commercial carriers active in the State's insurance market plummeted unexpectedly leaving consumers with a modest choice in health plan options. Within several months in the latter half of 1999, both Harvard Pilgrim Health Care of New England and Tufts Health Plan of New England departed from the Rhode Island insurance market without warning, leaving 150,000 Rhode Islanders at-risk of becoming uninsured. As a result, for many of those who were unable to afford the premiums charged by the remaining insurers in the State, enrollment in RIte Care was not only a viable option, but an attractive one as well. Over the previous five years, the RIte Care program had virtually erased the negative stigma usually associated with public programs.

The volatility in the commercial health insurance market and the incentives it provided for substitution of RIte Care for ESI were both likely to continue, thus a continued increase in RIte Care enrollment was predicted. In January 2000, such concerns prompted Governor Lincoln Almond to convene a group of Administration staff, legislative leaders, and consumer and business representatives to examine the factors contributing to the instability in Rhode Island's health insurance market and RIte Care's dramatic growth. During the six months that followed, the group focused on various mechanisms for moderating the volatility in the commercial insurance market and in RIte Care enrollment. After deliberating at length, the group agreed to pursue a package of health insurance initiatives designed to: (1) stabilize the costs of ESI for small businesses through both market access and rate reforms; and (2) provide low-

wage workers with assistance to obtain and/or maintain employer-sponsored health insurance coverage for their families. The Governor signed the resulting consensus legislative proposal, Health Reform Rhode Island 2000, into law on July 1, 2000.

D. Health Reform Rhode Island 2000

Health Reform Rhode Island 2000 contains three distinct initiatives, each which is designed to increase the availability of and access to quality, stable health insurance coverage. The three initiatives are as follows:

1. Establishment of RIte Share, a premium assistance program designed to provide subsidies to eligible low-income families with access to ESI;

2. Implementation of new regulations to reform the State's health insurance market and to stabilize the rates charged to small employers by health insurers; and

3. Creation of stronger financial accountability standards for health insurers.

The Department of Human Services (DHS) is responsible for implementing Initiative 1 of Health Reform Rhode Island 2000. To implement this initiative, the Act authorizes DHS to seek any State Plan Amendments, new waivers, or amendments of existing waivers under Titles XIX and XXI of the Social Security Act.

E. Implementation Requirements for Initiative One of Health Reform Rhode Island 2000

Upon reviewing the requirements of the Act, the Department of Human Services has determined that timely and effective implementation of the law requires:

- Amending the current Title XIX 1115 RIte Care waiver to establish affordability tests, waiting periods and cost-sharing requirements for 1115 expansion populations, consistent with HCFA draft SCHIP regulations for the purposes of deterring substitution and promoting responsible utilization of health care services;

- Approval of a Section 1115 waiver of Title XXI to allow the State to continue to: expand enrollment of low-income uninsured families in publicly funded family coverage; assist eligible low-income workers in obtaining and/or maintaining employer-sponsored family coverage through subsidies of such coverage; and impose cost sharing as well as deterrents for substitution; and

- Amending the Medicaid State Plan and SCHIP State Plan to reflect changes in coverage groups eligible under Title XIX and Title XXI. These State Amendments are not included in this current submission and will be submitted at a later date.

The Department has elected to submit a comprehensive proposal that explains the relevance and interaction between each of these key components. The most critical facet of the State's proposal is the request for a Section 1115 SCHIP waiver. It is the State's intent to use the demonstration authority granted under a Section 1115 SCHIP waiver to: promote access to affordable and quality family coverage; ease administrative burdens generally associated with SCHIP and Medicaid premium assistance programs; and target public funds to provide health insurance coverage for those most in need.

CHAPTER I

BACKGROUND

The RIte Care program, Rhode Island's Medicaid managed care program, purchases health insurance for approximately 11 percent of the state's population. The program is administered by the Center for Child and Family Health in the Rhode Island Department of Human Services. Over the past six years, RIte Care has significantly expanded access to health insurance for uninsured low-income children and families throughout the State. Currently, eligible populations covered under Title XIX or Title XXI include: all uninsured pregnant women with incomes up to 250 percent of the federal poverty level (FPL); uninsured children up to age 19 with incomes up to 250 percent of the FPL; and uninsured parents of enrolled children up to age 19 with incomes up to 185 percent of the FPL.

A. The RIte Care Section 1115 Waiver

RIte Care was implemented in 1994 under the authority of a Section 1115 Research and Demonstration waiver of Title XIX of the Social Security Act. Rhode Island has used the waiver's demonstration authority to create a comprehensive, coordinated health care delivery system via competitively procured contracts with licensed health maintenance organizations (HMO's or Health Plans). These contracts have provisions requiring participating Health Plans to adhere to specific quality, access and performance standards. As well, the contracts mandate health outcome measures to be reported to the Department, which are subsequently analyzed.

RIte Care has demonstrated excellent member satisfaction and significant improvements in health care access and health status indicators of recipients. Among the most significant are greater access to primary, pediatric, and prenatal care, increased inter-birth intervals, decreased maternal smoking, positive trends in addressing the incidence of low-birth weight among RIte Care newborns, and increased childhood immunization and lead screening rates.

RIte Care's Section 1115 waiver authority was also used to expand coverage to uninsured low-income families. As a result of this effort, in 1999 the rate of uninsured Rhode Islanders was reduced to a level that was the lowest in the nation at 6.9 percent (*See Attachment A*).

With the expansion of coverage to each new group, RIte Care enrollment has increased. The most dramatic rise in the number of enrollees followed the expansion in 1998 of eligibility to Section 1931 parents with incomes up to 185 percent of the FPL. Although increases in enrollment were expected,

the State was not prepared for the magnitude of the rise nor the consequences it posed for the RIte Care program and for Rhode Island more generally.

B. The Context And Consequences Of Increasing RIte Care Enrollment

Both the unintended and unexpected consequences of the rapid increase in RIte Care enrollment and State policymakers' responses to them are best understood in the broader context of recent developments in Rhode Island's health care system, particularly in the commercial health insurance market. Although Rhode Island has had a robust economy for much of the last decade, nearly one-third of the families in the State had incomes that fell below 200 percent of the federal poverty level. Unlike many of Rhode Island's sister States with high percentages of low- and moderate-income wage earners, the rate of uninsured in the State is the lowest in the nation at 6.9% according to the 1999 Census Bureau report (*See Attachment A*).

RIte Care, including its incremental expansions, has played an important role in maintaining a relatively low rate of uninsurance among the unemployed, low-wage workers, and children; however, the majority of working Rhode Islanders have continued to obtain coverage through employer-sponsored insurance (ESI). As of June 1999, the available data indicate that 77 percent of employers in the State offered ESI; 60 percent of employers who offer coverage paid the entire premium for individual coverage and 42 percent of employers who offer coverage paid the entire premium for family coverage (*See Attachment B*). In sum, for the better part of the last decade, RIte Care served as both the Governor and the General Assembly intended, as a means of providing coverage to uninsured individuals in these groups.

As the last decade came to a close it became increasingly more apparent that access to affordable health coverage in Rhode Island was beginning to erode. The sudden collapse of Harvard Pilgrim and the departure of Tufts Health Plan of New England from the Rhode Island market in January 2000, left many employers and employees with limited options for health care coverage (*See Attachment C*). The abrupt withdrawal of these two carriers from the commercial insurance market resulted in 150,000 Rhode Islanders at-risk of becoming uninsured. In addition, substantial increases in premium rates, particularly in the small group market, made purchasing health insurance unaffordable for many small employers and their employees.

Adding to the turmoil in the health insurance market over the last year is the growing perception, and the empirical evidence to support it, that an increasing number of workers with access to ESI are dropping or refusing coverage to enroll in the RIte Care program. Given the recent escalation in commercial premium costs, reports that some workers and businesses can no longer afford to purchase or retain ESI are not surprising. However, the two commercial insurers still active in RIte Care, United Health Care of New England (UHCNE) and Neighborhood Health Plan of Rhode Island (NHPRI), contend

that affordability of ESI is not the only reason eligible families shift to RIte Care. Both insurers argue that a significant number of individuals drop affordable ESI to enroll in RIte Care because the comprehensive coverage the plan provides can be obtained at little or no cost and without a waiting period. There is also anecdotal evidence that employers of primarily low- and moderate-income workers have dropped coverage for similar reasons - they do not have to contribute to the cost of coverage for workers enrolled in RIte Care. As State law prohibits employers from directing eligible employees into RIte Care, few employers will admit to engaging in this practice. Consequently, there is no hard data to support the reports of such activity on the part of employers.

In 1999, UHCNE, the only commercial carrier still accepting RIte Care participants at that time, reported approximately 30 percent of its new RIte Care enrollees had directly migrated from its commercial product(s) with no intervening period of uninsurance. The shift into RIte Care was due to many factors: expansions in eligibility; lack of provisions to deter substitution; an ambitious and successful outreach effort; and the dramatic increase in commercial insurance premiums over the previous year. Among the most important of these is the State's inability under Title XIX to adopt the eligibility requirements to deter Section 1931 parents from substituting RIte Care for ESI.

At the State's request, UHCNE conducted further analysis of the migration into RIte Care by two groups:

- Parents and children with family incomes between 185 percent and 250 percent of the FPL, a group easily identified due to cost sharing requirements; and

- Parents and children with family incomes below 185 percent of the FPL.

The results of UHCNE's analysis indicated that of the 4,200 RIte Care enrollees who switched from the insurer's commercial products, 95 percent had family incomes less than 185 percent of FPL - members of this coverage group were not subject to substitution deterrents.

As 1999 drew to a close, both the Governor and the Rhode Island General Assembly became concerned that continued migration into RIte Care would not only pose significant State budget shortfalls, but would also further erode the employer-sponsored health insurance market. Evidence that substitution was increasing as a result of the November 1998 expansion to working families, coupled with the unprecedented rise in program costs, heightened the sense of the Governor and key legislators that the time had come to redirect the RIte Care program to meet its original goal of providing coverage to the *truly* uninsured.

C. The Health Care Steering Committee

In January of 2000, Governor Lincoln Almond convened a group of Administration staff, legislative leaders and consumer and business representatives to find solutions to Rhode Island's deteriorating health insurance market. The Health Care Steering Committee, as the workgroup was called, was jointly chaired by: Christine Ferguson, Director of the Rhode Island Department of Human Services (DHS); Senator Thomas Izzo, Chair of the Senate HEW Committee; and Representative Gerard

Martineau, House Majority Leader. The Steering Committee was broadly representative of employers, consumers, labor and legislative and executive branches of government. Health care providers and insurers were invited to attend and provide testimony to the Committee. A detailed overview of the Steering Committee membership is located in *Attachment D.*

During the next six months, the group focused on methods of stabilizing the employer-based health insurance market. Specifically, the group examined methods to enable small businesses to maintain ESI by stabilizing premium rates and by assisting and encouraging low-wage workers to maintain ESI. The focus on small employers was due to the increasing number of businesses with less than 50 workers reporting the most volatile rate increases and the resulting difficulty in maintaining and/or obtaining ESI, as well the vital role these employers play in the State's overall economic health.

The Governor signed the resulting consensus legislative proposal into law on July 1, 2000. The legislation, Health Reform Rhode Island 2000, includes the following components, each of which advances the larger goal of ensuring that all Rhode Islanders have access to affordable health care:

1) Directing the Department of Human Services to stabilize the RIte Care program by targeting resources at those who are most in need of coverage – low-income families without access to affordable coverage, by:

    a) Authorizing Rhode Island's Department of Human Services to establish eligibility requirements for RIte Care to deter substitution (i.e., affordability tests and waiting periods).

    b) Establishing cost sharing requirements for certain RIte Care eligible populations to promote both responsible utilization of health care services and the development of additional disincentives for substitution.

    c) Mandatory participation in RIte Share of eligible individuals and families who have access to ESI. RIte Share is the premium assistance program established by the Act to support employees in purchasing or maintaining ESI.

    d) Elimination of three-month retroactive eligibility for certain RIte Care eligible groups.

2) Reform of the health insurance market to: conform with the Health Insurance Portability and Accountability Act (HIPAA) of 1996; stabilize premiums in the small group market by compressing rate bands; and guarantee issue of a basic health plan.

3) Establishment of new financial reserve requirements for health insurers consistent with the National Association of Insurance Commissioners (NAIC).

The Act also created the Permanent Joint Committee on Health Care Oversight, a bicameral, bi-partisan, 8-member committee, charged with advising both the House and Senate on matters related to health care. The Committee's chief responsibility is to oversee the implementation of the programs

created under the Act. In addition, the Advisory Commission on Health Care was created to advise the director of the Department of Human Services on all health care matters, including the RIte Care and RIte Share programs. The Advisory Commission is comprised of 15 members representing consumers, employers, providers, insurers and other government entities and is chaired by the Director of the Department of Human Services.

With the passage of Initiative One of the Health Reform Rhode Island 2000 Act, there was also a significant and important consensus agreed to by both the Governor and General Assembly leaders: RIte Care must be redirected to its original mission to provide coverage to the truly uninsured and continual migration from ESI to Rite Care could not persist. If effective provisions to deter substitution are not quickly approved and implemented, the State will instead roll-back eligibility expansions currently in place for working families, in particular the 1931 expansion implemented in 1998 for parents above TANF income levels.

The Department of Human Services was required to and has filed an implementation plan with the Permanent Joint Committee on Health Care Oversight on August 1, 2000.

CHAPTER II

DEMONSTRATION DESIGN

One of the centerpieces of Health Reform Rhode Island 2000 is the establishment of RIte Share, a premium assistance program for low-wage workers and their dependents. The RIte Share program will use public funds to subsidize employer-sponsored health insurance premiums for all RIte Care eligible employees and their dependents that have access to a qualified health plan.

Implementation of certain components of the RIte Share premium assistance program requires a Section 1115 waiver of Title XXI (SCHIP). In its July 31, 2000, *Dear State Health Officials* letter, HCFA provides guidance to States preparing to submit requests for Section 1115 waivers of Title XXI. The guidance establishes certain minimum criteria that a State must meet to qualify to submit a waiver request, outlines the purpose of SCHIP demonstration projects, and identifies the types of information States should include to justify waiver requests. In keeping with the HCFA guidance, each of these matters is addressed in turn below.

A. Qualifications To Submit A SCHIP Section 1115 Waiver

As the following indicates, Rhode Island has met and in many cases, exceeds the criteria set forth by HCFA to qualify to submit a waiver request.

1. Rhode Island has more than one year of experience providing SCHIP coverage to children with family incomes up to 250 percent of the FPL.

On October 1, 1997, Rhode Island implemented its SCHIP Program by covering uninsured children ages 8 to 18, with family incomes up to 250 percent of the FPL under a SCHIP Medicaid expansion that was originally implemented under Medicaid authority in May 1997. In 1999, SCHIP coverage was further expanded to include uninsured children up to age 19 in the same income group. At the time the SCHIP State Plan was implemented, Rhode Island had already extended coverage to children ages 0 to 8 with incomes up to 250 percent of the FPL under a Medicaid expansion. The income eligibility cut-off of 250 percent of the FPL for RIte Care/ SCHIP eligible children exceeds the target income range of 200 percent of the FPL established in Title XXI.

2. The State has met the primary goals of SCHIP by expanding eligibility to and providing coverage for the core population of targeted low-income children.

Since its inception in 1997, Rhode Island's SCHIP program has worked in tandem with RIte Care waiver expansions to effectively decrease the number of low-income children without health insurance. For example, according to The Current Population Survey, the number of uninsured children and families with incomes at or below 200 percent of the FPL declined by 27 percent between 1996 and 1998 when compared to the previous three year average (1995-1997) (*See Attachment E*). Moreover, State-specific outreach reports as of October 2000, reveal approximately 2 percent of the children residing in Rhode Island are uninsured (*See Attachment F*). RIte Care currently covers 68,500 children, of which 9,800 are covered under SCHIP and 56,900 are covered under Medicaid, representing 28.5 percent of Rhode Island's 240,000 children. These data demonstrate the State's effectiveness in enrolling the targeted low-income children SCHIP was intended to serve.

3. The State provides continuous enrollment for children in the SCHIP program.

As Rhode Island elected to provide coverage under its SCHIP State Plan as a Medicaid expansion, children eligible for coverage are afforded the safeguards incumbent with an entitlement program. Eligible children are not subject to waiting lists, delays or interruptions in coverage due to spending or enrollment limits. In fact, the State is committed both in principle and as a matter of law to maintain continuous, open enrollment for all eligible children (*See Attachment G*).

4. Rhode Island's streamlined application and re-determination process for SCHIP and Medicaid promotes enrollment and retention of eligible children.

Shortly after the implementation of its SCHIP program, Rhode Island implemented the following policies and procedures to facilitate enrollment and retention of eligible children:

- Use of a joint, simplified mail-in application for SCHIP and Medicaid with questions stated in English and Spanish.
- Elimination all verification requirements other than proof of income, and where appropriate, pregnancy, and immigration status (Rhode Island had previously eliminated all assets tests).
- Mail-in re-certification.

5. The State regularly submits both SCHIP and RIte Care evaluations to HCFA.

On March 1, 2000, the State submitted to HCFA its required SCHIP evaluation (*See Attachment H*). Both quarterly and annual reports are also submitted in a timely manner. In addition, to meet the requirements for the RIte Care waiver demonstration project, the State conducts a comprehensive evaluation of health care outcomes for both its SCHIP and Medicaid populations on an annual basis. These evaluations are widely regarded as a model for other States.

In summary, the State has clearly met all of the prerequisites to submit a SCHIP waiver request established in the July 2000, guidance from HCFA.

B. Goals Of The SCHIP Waiver Demonstration Design

As the following illustrates, each of these goals has merit on its own, as well as in relationship to both the objectives of Title XXI and the State's long-standing commitment to ensure that every Rhode Islander has access to affordable health care coverage. The methodology the State will use for evaluating each of these goals is provided in detail in the *Chapter VII, Program Evaluation*. It is the State's intent to use the demonstration authority granted under a Section 1115 SCHIP waiver to achieve the following goals and objectives:

Goal 1:

To improve the health status of Rhode Islanders by improving access to and quality of health care.

Objectives:

a) To increase the number of low-income children who utilize age-appropriate preventive care services as a result of being enrolled in family coverage.

b) To decrease uninsurance, expand health care access, improve health status, and promote appropriate utilization of health care services of Rhode Islanders by increasing enrollment in RIte Share.

c) To improve health status and appropriate utilization by providing expanded benefits with no significant costs for such expanded benefits. The State will assess the impact of providing expanded benefits under Medicaid beyond the those offered in commercial products, namely an expanded medical necessity definition, no day limits on behavioral health services, and assignment of a primary care provider (PCP), on the following: health status, utilization and cost for RIte Care and RIte Share compared to populations with non-subsidized commercial coverage.

d) To decrease the rate of uninsurance by implementing affordability tests and waiting periods for RIte Care (those who are affected by the tests will retain ESI, thus allowing the State to target program resources to those without access to affordable ESI).

e) To promote appropriate utilization of health care services by establishing effective co-payment levels. In particular, the State expects the established co-payment level for non-emergent/non-urgent emergency room services or for an emergency room visit that does not result in an admission will encourage appropriate utilization of preventive health care

services, such as ambulatory primary care services and deter non-emergent, non-urgent emergency room utilization for ambulatory sensitive conditions.

f) To assure access to all needed medications, specifically increase the use of generic medications when appropriate by implementing affordable pharmacy co-payments with differential levels for generic and brand prescriptions.

Goal 2:

To reduce the rate of uninsurance in Rhode Island by maximizing Rhode Islander's access to affordable health insurance coverage by leveraging the use of public and private funds (enhanced SCHIP match for certain coverage groups as well as employer dollars as a result of participation in the premium assistance program).

Objectives:

a) To increase total enrollment in public coverage while shifting enrollment from full public coverage (RIte Care) to partially subsidized coverage (RIte Share).

b) To increase the number of low-income children with health insurance by providing health insurance to their parents.

c) To leverage available employer dollars to reduce the rate of uninsurance by maximizing enrollment of clients, employers and Health Plans in RIte Share by decreasing the administrative burden generally associated with SCHIP and Medicaid premium assistance programs for the following: (a) enrollees; (b) employers; (c) the State; and (d) Health Plans.

d) To ensure public funds are targeted at reducing the rate of uninsurance, thereby not replacing funds used to purchase ESI. The affordability tests and waiting periods have been established at a level to make certain those who have been able to afford to purchase employer-sponsored health insurance will retain that health insurance offered by their employer i.e. deter substitution of ESI for publicly funded health insurance. It is the State's intent to assure the affordability tests and waiting periods are effective in deterring substitution and that those that are denied eligibility by the tests indeed retain employer-sponsored coverage.

Goal 3:

To serve as a pilot program to demonstrate an innovative method for successfully developing and implementing a combined Medicaid and SCHIP premium assistance program.

Objectives:

a) To maximize enrollment in the RIte Share Premium Assistance Program by simplifying administrative procedures for enrollees, Health Plans, employers and the State.

b) To maximize cost savings through the RIte Share Premium Assistance Program by waiving certain SCHIP provisions, specifically using a more flexible methodology for determining cost effectiveness (waiving the 60 percent employer contribution requirement, calculating cost effectiveness on a population by population basis in lieu of family by family, and certifying Health Plan's products using standards for a basic health plan instead of certifying products offered by each employer.).

C. Components of the SCHIP Demonstration Design

The State is requesting the authority to waive or extend certain SCHIP requirements, each of which is explained in detail below.

1. Enrollment of Section 1931 Expansion Parents and Relative Caretakers, Pregnant Women, and Families Covered under Extended Medical Assistance (MA) in SCHIP

The State is requesting a SCHIP 1115 waiver to extend family coverage under SCHIP to:

- Section 1931 expansion parents and relative caretakers (November 1998 expansion group) with incomes below 185 percent of the FPL;
- Families covered under Extended Medical Assistance (MA); and
- Pregnant women with incomes between 185 percent and 250 percent of the FPL.

Rationale

The State firmly believes that extending health care coverage to parents and relative caretakers is essential for increasing enrollment of targeted children in the SCHIP program, encouraging and assuring the appropriate use of preventive and other services, and managing health care costs. As noted in a May 1998 publication by the Academy of Health Services Research and Health Policy, entitled State Initiatives in Health Care Reform*:* "Enrollment take-up rates can be as much as 30 percent higher when the family unit is involved than when enrollment is limited to some or all of the children in a family" (*See Attachment I*). Children's health care literature is replete with studies that expand on this argument: not only is family-based coverage generally found to be more effective than child-only coverage in reducing the rate of uninsurance (*See Attachment J*), but the health status of the entire family tends to improve as well. Furthermore, providing coverage to parents and children under the same plan has also been found

to encourage use of primary and preventive services; this, in turn, decreases the levels of unmet needs that disproportionately affect lower-income populations.

Making family coverage through ESI more readily available to Extended MA recipients will assist in achieving many of these same objectives. It has the additional advantage of permitting eligible workers to take full advantage of the benefit packages offered by employers. For example, research conducted by both the Commonwealth Fund and the Employee Retirement Benefit Institute indicates employers often adjust wages downward to offset the costs for health insurance for low-income workers (*See Attachment K*). Although these studies indicate some employers offer higher wages or provide cash in-lieu of benefits to employees that choose not to enroll in ESI, the majority of small businesses do not provide workers with alternative forms of compensation. Moreover, there is evidence that low-income workers who obtain individual coverage through ESI often opt to cover their children under Medicaid or SCHIP rather than pay the higher costs of family/dependent coverage. As a result, it is not uncommon for parents and children in families in Extended MA to be covered by separate plans, each with different provider networks and benefit levels. Thus, enrolling extended MA families in RIte Share will expand access to family coverage by making use of resources (i.e., employer contribution to ESI) that would otherwise be unavailable, while providing these families with access to one coordinated system of care and coverage.

The State will be able to access approximately 31 million dollars in enhanced Federal Medical Assistance Participation (FMAP) over the next three years by shifting coverage of 1931 expansion parents, Extended MA participants, and pregnant women with incomes between 185 percent and 250 percent of the FPL from a Medicaid State Plan or waiver to a SCHIP Medicaid expansion. The additional funds the State receives through the enhanced match will allow the State to continue to provide coverage for and significantly increase enrollment of low-income target families without access to affordable coverage. As a result, more of their children will be enrolled. The establishment of the RIte Share premium assistance program as part of the SCHIP waiver will be in and of itself, a significant deterrent for substitution and one that will ultimately contain costs. The dollars saved will be reinvested to expand enrollment of eligible uninsured families and to preserve the quality of the services and choice of Health Plans available to them.

One of the chief goals of the proposed demonstration project is to maximize access to family coverage by making optimal use of all available resources. The State is convinced that making family coverage more readily accessible will reduce the number of uninsured children. The SCHIP waiver is necessary both to maintain and expand enrollment of eligible parents with incomes below 185 percent of the FPL, to preserve the important gains Rhode Island has already made in providing targeted low-income children with quality health coverage and to continue to expand enrollment of eligible children. In this respect, the additional dollars Rhode Island receives under the SCHIP waiver will be used to augment rather than to supplant the funds the State has already committed to achieve the goals of SCHIP. In fact, the State projects that with approval of the SCHIP waiver, the State's enrollment in RIte Care/RIte Share combined will grow to more than 130,000 in the next three years.

2. Affordability Tests and Waiting Periods

To preclude further migration of families with access to ESI into RIte Care, "substitution", the State is requesting to establish waiting periods and affordability tests for enrollment in both the RIte Care and RIte Share programs. The State's proposed substitution provisions are consistent with the basic goals of Title XXI and with the requirements established in SCHIP draft regulations.

As stated in the draft SCHIP regulations: "Employers who make contributions to coverage for dependents of lower-wage employees could potentially save money if they reduce or eliminate their contributions for such coverage and encourage their employees to enroll their children in CHIP. At the same time, families that make significant contributions towards dependent group health coverage could have an incentive to drop that coverage and enroll their children in CHIP if the benefits would be comparable or better and their out-of-pocket costs would be reduced (*See Attachment L*)." Accordingly, the State is seeking to establish specific provisions, consistent with HCFA's SCHIP requirements to protect against substitution and to serve as a mechanism to target RIte Care to uninsured, low-income families. The affordability tests and waiting periods are defined as follows:

- Any new applicant whose share of health care premium is less than 50 percent of the total cost of coverage (dollar amount reflecting Rhode Island rates, approximately less than $150/month for individual coverage or less than $300/month contribution for family coverage, to be defined in regulation) and who has participated in any health coverage ("not gone bare") for the last six months cannot enroll.

- Any new applicant who has lost coverage in the past six months as a result of an employer who dropped coverage specifically for a class of employees who would qualify for RIte Care cannot enroll.

Rationale

The State is proposing a six-month waiting period for new applicants who may have "affordable" ESI or who have recently lost or dropped ESI coverage to ensure that coverage is targeted to families who *truly* cannot afford private health insurance coverage. A minimum waiting period of six months was chosen to conform with the following draft SCHIP regulations: "…this time period is long enough to significantly deter families from dropping existing coverage (*See Attachment L*)." In essence, a family that is uninsured for at least six months ensures that coverage is targeted to families who were truly unable to afford coverage.

"Affordable" health care coverage will be defined in the regulations as individual coverage that costs less than approximately $150/month for individual coverage and $300/month for family coverage. This represents approximately 50 percent of the average cost of health insurance premiums in Rhode Island. According to a September 2000 Kaiser Family Foundation Survey of employer-sponsored health benefits, the average monthly premiums for Preferred Provider Organizations (PPO) Plans in the northeastern region was approximately $240/month for individual coverage and $617/month for family coverage (See Attachment M). State-specific data from the State of Rhode Island Payroll Manual and

Blue Cross Blue Shield of Rhode Island indicate the approximate range of health insurance premiums for small and large groups are as follows: individual coverage, $207-$243/month; and family coverage, $580-$707/month. As evidenced by this information, the State has chosen a reasonable definition of "affordable" health insurance.

Draft SCHIP regulations note: "States that have approved Medicaid demonstration projects under Section 1115 (a)(2) that currently apply substitution provisions, such as waiting periods, to expansion populations under this demonstration may continue to do so (*See Attachment L*)." Therefore, the State requests amending the current SCHIP waiver to apply the affordability tests and waiting periods to which have been previously approved and used under the 1115 waiver to apply to the following populations: Section 1931 expansion parents and relative caretakers with incomes between 110 percent of the FPL and 185 percent of the FPL; children ages 1 to 6 with family incomes greater than 133 percent of the FPL; infants ages 0 to 1 with family incomes greater than 185 percent of the FPL; children ages 6 to 8 with family incomes greater than 110 percent of the FPL; and children ages 8 through 18 with incomes greater than 110 percent of the FPL. Affordability tests and waiting periods will not apply to pregnant women and newborns born to enrolled women. These provisions will be applied to individuals within a family rather than the family unit.

In view of the recent surge in RIte Care enrollment and the decline in ESI, the State is committed to reducing substitution to preserve RIte Care for the truly uninsured and to promote continued viability of the Rhode Island commercial insurance market. The State is convinced the affordability tests and waiting periods included in this proposal will achieve those goals for the following reasons.

First, the affordability tests and waiting periods are simple to administer. The information necessary to determine whether an applicant has affordable ESI and what, if any, waiting period should apply can be readily obtained from the application and/or through documents verifying income (e.g., pay stubs), therefore ensuring the application process itself does not pose a barrier to enrollment for those who are eligible.

Second, both the affordability tests and waiting periods the State has selected have proven to be effective deterrents for substitution in other States. The current four-month waiting period for children with affordable ESI with incomes from 185 percent to 250 percent of the FPL affects a very limited number of applicants. Therefore, the State has chosen to modify its existing affordability test and waiting period to one that has been previously approved and used for the first four years of the Section 1115 RIte Care waiver and which will be consistent with HCFA's SCHIP regulations. As such, the State is confident it will be better able to target resources at families who truly cannot afford private health insurance coverage by implementing a six-month waiting period combined with an affordability test.

Third, the State's proposal to restrict eligibility for six months if an employer drops or cancels ESI is targeted at businesses that encourage substitution. Although the requirement may seem unduly punitive to potential recipients, it is designed to reinforce existing provisions in State and Federal laws that prohibit employers from terminating coverage for workers because they are eligible for MA.

Specifically, State law provides that any business that discriminates against or acts unfairly toward an employee or class of employees based on their eligibility for MA is subject to civil penalties. Terminating or denying RIte Care eligible workers access to ESI is clearly punishable under these provisions. However, recent experience indicates this kind of discrimination is difficult to prove.

During the last year, it was reported that several employers encouraged their RIte Care eligible workers to drop ESI and enroll in RIte Care. DHS has made an effort to verify these reports but was unable to obtain the level of evidence necessary to prove that discrimination based on Medicaid eligibility occurred. Employers are unwilling to admit to such actions because they may be sanctioned and workers are reluctant to come forward out of fear they may face retribution from employers. When confronted with a similar dilemma, Minnesota established a six-month waiting period for Medicaid enrollment for any employee whose insurance was dropped by an employer. This provided a strong disincentive for employers to drop/cancel coverage. Since workers cannot enroll directly into the Medicaid program and must go "bare," employers risk losing their best skilled employees to competitors who provide coverage. The Department believes this same approach will have a similar impact in Rhode Island without imposing undue hardship on families.

In a tight labor market there will be relatively few employers that are willing to cancel coverage for an entire class of employees, thus forcing them to become uninsured for six months. Competition for experienced and skilled workers in a business environment where more than 75 percent of the employers provide ESI assures that the six-month eligibility restriction will apply only in a small number of cases, by providing a very strong disincentive for employers to cancel coverage for a select group of workers.

Eligibility will not be restricted for families who lose employer-sponsored coverage as a result of: (a) the loss of dependent coverage due to death, divorce, or separation; (b) lay-off or reduction in work force; (c) the closure or relocation of an employer; or (d) loss of job due to illness or disability.

Due to their definitions, affordability tests and waiting periods will only impact new applicants. Thus, no current enrollees will be disenrolled due to affordability tests and waiting periods. Pregnant women and newborns born to enrolled women will not be subject to the affordability tests and waiting periods.

The State will implement procedures to monitor the extent of substitution of SCHIP coverage for existing private group health coverage for all families by income level. Additionally, the State will consider requesting a modification of these provisions to prevent substitution in the event that monitoring efforts reveal substitution continues to occur at an unacceptable level or that significant numbers of those denied eligibility due to affordability tests and waiting periods become uninsured. Self-employed individuals will be excluded from the affordability tests and waiting periods.

* A new applicant is defined as an individual who has never participated in RIte Care or who has failed to re-certify within 30 days of the re-certification deadline.

See *Attachment N* for details of '*good-cause*'.

3. Cost Sharing Provisions

The State proposes to implement cost sharing provisions in RIte Care/RIte Share to deter substitution, to eliminate the "welfare stigma" associated with public health insurance programs, to encourage awareness of health care costs and to encourage appropriate use of health care services. The State will implement cost sharing including a combination of point of service co-payments and monthly premiums for families with incomes greater than 150 percent of the FPL. The State has opted to institute point of service co-payments with a 3 percent annual cumulative cap of family income on total family cost sharing beginning February 1, 2001, and will implement premium sharing when an effective system is developed to ensure families subject to both co-payments and premium share do not exceed the 3 percent family income maximum.

To comply with Federal requirements and to assure that "poor" families do not face unreasonable burdens when enrolled in RIte Care/RIte Share, cost sharing will not apply to families with incomes below 150 percent of the FPL. This provision is consistent with draft SCHIP regulations that allow cost sharing of up to five percent of family income for enrollees with incomes above 150 percent of the FPL.

Emergency Room Co-payments

Since RIte Care was established, the rate of overall emergency room utilization of MA recipients has dropped appreciably. However, RIte Care members utilize emergency services at a rate twice that of members of commercial plans. At the present time, there is no requirement of co-payment for emergency room visits for RIte Care recipients or for coverage of medical screening. By contrast, point of service co-payments for emergency room visits, using the prudent lay-person standard, are included in all commercial plans currently marketed in the State (*See Attachment O*). The proposed $25 co-payment schedule for the RIte Care and RIte Share programs for emergency room visits applies only under the following conditions:

- Emergency room visits that are: non-emergent; non-urgent (using HCFA's Medicare definition, *See Attachment O*); or does not result in an admission.

Prescription Co-payments

The State also proposes instituting point of service co-payments for the RIte Care and RIte Share programs for prescription drugs, again limited to those with incomes above 150 percent of FPL. The proposed co-payment schedule is as follows:

- $5 generic prescriptions; and
- $10 non-generic prescriptions.

Rationale

One of the purposes of Health Reform Rhode Island 2000 is to redesign RIte Care to more closely resemble products available in the commercial market so as not to encourage substitution from ESI to public coverage. As the side-by-side comparison of benefits of RIte Care and the dominant commercial plans in the State indicates, the key difference between the public and private plans is in cost sharing requirements (*See Attachment P*). Accordingly, the State's proposal to revise its existing point of service co-payment schedule implemented under the RIte Care waiver is designed, in part to make RIte Care more comparable to commercial plans, to promote responsible use of health care services and to deter substitution.

In the course of its deliberations, the Health Care Steering Committee was presented with testimony from representatives of the State's commercial insurers, hospitals and health care facilities focusing on key differences between RIte Care and private plans. The absence of an emergency department co-payment was generally agreed to be particularly problematic, in view of its potential to deter over-utilization of expensive, acute care services. Thus, the State's primary goal in implementing a co-payment for emergency room visits is to address both the comparability and utilization issues raised before the Steering Committee.

The industry standard in Rhode Island for emergency room co-payments averages approximately fifty dollars. The State believes a $25 co-payment for non-emergent/non-urgent use of the emergency room or for a visit that does not result in an admission for individuals with incomes above 150 percent of the FPL will promote responsible utilization without deterring those in need from obtaining services. Research focused on emergency room co-payments supports this view: at higher income levels (i.e., 150 percent and above), point-of-service co-payments of $25 or less generally do not deter individuals from seeking necessary emergency services when participating in a managed care plan similar to RIte Care.[1]

RIte Care's lack of co-payments for prescription drugs also poses comparability and utilization issues. In Rhode Island, the ability to manage pharmaceutical benefits is complicated by a provision in State law prohibiting managed care plans from requiring participating practitioners to prescribe generic drugs or formulary drugs. The law also allows practitioners to prescribe, and individuals to be reimbursed for, non-generic and non-formulary drugs under a broad range of circumstances. In short, the vagaries of State law make it more difficult in RI than in most other states to manage pharmaceutical benefits without distinguishing between generic and non-generic drugs. The State is requesting to change point of service co-payments to $5 generic and $10 non-generic for those with incomes above 150 percent of FPL. These are well below the average of $15 and $20 co-payments charged, respectively, by commercial plans in the Rhode Island market.

Draft SCHIP regulations note: "States may use mechanisms other than eligibility restrictions to discourage substitution of coverage (*See Attachment L*)." Therefore, to assist in deterring substitution, the State proposes to amend its cost sharing requirements for the following enrollees (to be applied to

1. See Devin O'Grady, et.al, "The Impact of Cost Sharing on Emergency Department Use," *New England Journal of Medicine*. 313(1994): 484-90.

both applicants and current recipients enrolled in both RIte Care and RIte Share): Section 1931 expansion parents and relative caretakers with incomes greater than 150 percent of the FPL; pregnant women, newborns and infants ages 0 to 1 with family incomes greater than 185 percent of the FPL; and children ages 1 through 18 (19th birthday) with family incomes greater than 150 percent of the FPL.

Since cost sharing poses a unique financial barrier to care for American Indian/Alaskan Native (AI/AN) children covered under Title XXI, the State will not impose cost sharing on AI/AN children in accordance with the access provision of Section 2102(b)(3).

Total annual aggregate cost sharing will be limited to 3 percent of family income. This figure is below HCFA's five percent limit for those with incomes above 150 percent of FPL. The State will track cost sharing by a combination of two methods. First, the Health Plan providing coverage will be required to track the amount of co-payments paid and re-issue an ID card to the recipient specifying no cost sharing once the maximum dollar amount has been met. Second, the enrollee will be allowed to use the traditional "shoebox method." There will be no disenrollment provision for nonpayment of co-payments.

CHAPTER III
COST EFFECTIVENESS

The State is requesting a Section 1115 waiver of Title XXI that necessitates a family-by-family cost-effectiveness assessment for those covered by SCHIP and enrolled in a premium assistance program. The State is also requesting to waive the draft SCHIP regulation restricting premium assistance to plans in which the employer contributes at least 60 percent towards the family premium. Instead, the State proposes to define an upper dollar limit or ceiling for subsidizing family coverage, without regard to family size. Similarly, the State also plans to establish a ceiling for individual coverage. In both instances, the dollar limit will be actuarially determined so as to ensure that *on average*, families enrolled in RIte Share will cost less than if the State enrolled that same group of families in fully subsidized RIte Care. This will be continually monitored and measured by the State and reported to HCFA annually. Cost effectiveness will be calculated by totaling RIte Share premium subsidies and out-of-plan services/wrap around services and comparing this to what it would have cost using RIte Care age/sex specific capitation rates, if the RIte Share population had been enrolled in RIte Care, again including both in-plan and out-of-plan services.

The State feels strongly this method of measuring cost effectiveness for the purposes of enrollment in the RIte Share premium assistance program will be the key to maximum enrollment in this program. The State has examined the specific experiences of other States operating a premium assistance program which report significant administrative burdens on both the State and employers in collecting the amount of information necessary and then calculating family-by-family cost effectiveness testing. Rhode Island is proposing to use this 1115 waiver, in part to demonstrate an alternative method of administering a premium assistance program which will decrease administrative burdens to employers and the State, to maximize enrollment in the premium assistance program and to leverage public and employer funds to maximize enrollment in publicly supported health care coverage.

With respect to Title XIX, the State will determine cost-effectiveness for covered individuals to determine enrollment in RIte Share using the same methodology. Section 1906(e)(2) permits States to define the methods by which cost-effectiveness can be determined.

According to draft SCHIP draft regulations provided in the *Federal Register*, the "employer must make a substantial contribution to the cost of family coverage, equal to 60 percent of the total cost of family coverage (*See Attachment L*)." In the Rhode Island market, employer contribution varies from 50 percent of individual (employee only) coverage, which is the minimum required through insurer underwriting rules, to a maximum of 100 percent of family coverage. According to the 1999 Survey of Rhode Island Employers, of the 77 percent of employers in Rhode Island with three or more employees who offer group health insurance, 97 percent paid some or all of the premium. The majority of Rhode Island employers who offer coverage (60 percent) pay the full cost of individual (employee only) coverage for their employees. Only 42 percent pay the full cost of family coverage (*See Attachment B*).

However, the reason for HCFA's minimum employer contribution requirement is primarily to ensure that enrolling the family in employer coverage instead of full public coverage will be cost effective. That is, it will cost less in public funds to subsidize employer-sponsored health insurance coverage than it would be to provide full public coverage. Rhode Island will use a different methodology, as previously explained to assure that enrollment of the RIte Share Premium Assistance Program population will cost less in public funds than if that same population was enrolled in RIte Care. Thus, Rhode Island requests a waiver of the 60 percent employer contribution requirement. This will allow the maximum number of families meeting Rhode Island's cost effectiveness test to be enrolled in RIte Share. This will allow Rhode Island to most effectively use its limited public funds (Title XXI with its State-specific allowance; Title XIX limited by budget neutrality; State funds limited by annual appropriation) to cover the maximum number of families with fully comprehensive, quality health coverage.

Data obtained from the 1999 Employer Survey, as well as from the Employer and Insurance Broker Focus Group indicate that Rhode Island employers are committed to providing health insurance to employees and, whenever financially feasible, to their families in order to maintain a healthy and productive workforce. The RIte Share premium assistance program will aid employers in meeting this commitment by giving workers the financial assistance they need to obtain and/or maintain coverage for themselves and their dependents. By making ESI more affordable for low-income working parents and their children that otherwise might go uninsured, RIte Share further advances the primary goals of SCHIP.

A. Summary of RIte Share Covered Services

The legislation passed by the Rhode Island General Assembly authorizing the Department of Human Services to establish the RIte Share Health Insurance Premium Assistance Program stipulates that "the Department must determine that the benefits offered by the employer-based health insurance plan are substantially similar in amount, scope and duration to the benefits provided to RIte Care eligible persons by the RIte Care Program, when such plan is evaluated in conjunction with available supplemental benefits provided by the Department" (*See Attached Legislation, Chapter 40-8.4-12(d)*).

The Department intends to use the "basic health plan" (*See Attached Legislation, Chapter 27-50-10(D)*), to be developed in consultation with the Rhode Island Department of Business Regulation, as a vehicle for complying with this requirement. Because of the commonality in scope of covered services offered by the limited number of Health Plans serving the Rhode Island employer-sponsored health insurance market (*See Section on Cost Effectiveness*) and the similarity to the RIte Care scope of covered services, the Department will require that the basic health plan include at a minimum, a scope of services which covers most of the services covered by RIte Care.

However, employer-sponsored health insurance normally includes co-payments for ambulatory services that typically vary from employer to employer. Employers may find it difficult and in fact, in conflict with Employee Retirement Income Security Act (ERISA) requirements to offer a health insurance plan to employees eligible for Medical Assistance that differs from that offered to other employees. Moreover, most

employers will not be willing to increase the health benefits offered to their employees in order to accommodate the requirements of the RIte Share program. Therefore, the Department intends to propose requirements for the basic health plan that stipulate maximum co-payment levels which are consistent with the high end of the range of co-payments offered in the Rhode Island commercial market. Any employer-sponsored plan underwritten by a RIte Care participating Health Plan that meets the requirements of the basic health plan in terms of the minimum required scope of covered services, co-payments that do not exceed the maximums allowed, and where the Health Plan agrees that RIte Share members choose or are assigned a participating primary care physician will be eligible for the RIte Share Premium Assistance Program.

The Department will contract directly with the RIte Care participating Health Plans for supplemental benefits which will assure that RIte Share recipients will not be required to pay co-payments at the point of service, except those specified as being included in the RIte Care program for participants with incomes over 150 percent of the FPL.

Certain health care services covered by RIte Care that are not generally covered by employer-based health insurance will be provided through a wrap-around benefit program provided by DHS. This wrap around benefit will be provided by a combination of directly purchasing supplemental benefits from the insurers and providing benefits through Medicaid fee-for-service. Supplemental benefits that will be purchased directly from insurers will include coverage of co-payments that may be included in the employer-sponsored health insurance program, certain Medicaid covered over-the-counter medications and behavioral health benefits beyond commercial visit limits. Benefits that will be provided through Medicaid fee-for-service wrap around will include services covered as currently done for RIte Care enrollees, such as dental services.

Attachment Q illustrates how the various components are equivalent to the RIte Care benefit level. This approach has several advantages:

- The basic health plan will be compatible with employer-based health insurance programs generally offered in the market, maximizing employer and insurer participation.

- RIte Care eligible families will experience, in the aggregate, common benefits whether they are covered by employer-based health insurance or directly under RIte Care, assuring participant acceptance of RIte Share as the vehicle for delivering the Medical Assistance benefits for which they qualify.

- Both RIte Share and RIte Care will deliver services utilizing primary care physicians that

participate, in most cases, in all participating Health Plans. Thus, continuity of health insurance coverage and therefore, medical care, is maintained for the eligible family with working members.

CHAPTER IV
WAIVERS REQUESTED

Rhode Island's Section 1115 waiver combines a freedom of choice waiver that allows mandatory enrollment in managed care with coverage of expansion populations. RIte Care currently encompasses the Temporary Assistance to Needy Families (TANF) and TANF-related populations, families on Extended Medical Assistance (MA), pregnant women and children eligible under "poverty level" expansions of Omnibus Budget Reconciliation Act (OBRA) 1989 and 1990, SCHIP children ages 8 through 18 (19th birthday) with incomes up to 250 percent of the FPL, 1115 Medicaid waiver expansions to pregnant women and children ages 0 to 8 with incomes up to 250 percent of the FPL, and Section 1931 expansion parents and relative caretakers with incomes up to 185 percent of the FPL.

To provide families with continuous enrollment and continuity in coverage, the State is:

- **Requesting a SCHIP Section 1115 waiver of Title XXI that provides health care coverage under Title XXI to:**

    - Section 1931 expansion parents and relative caretakers with incomes up to 185 percent of the FPL;
    - Families covered under Extended Medical Assistance (MA); and
    - Pregnant women with incomes between 185 percent and 250 percent of the FPL.

- **The Section 1115 waiver of Title XXI will also be used to:**

    - Waive the cost effectiveness test for family coverage under SCHIP and replace with SCHIP allowance for Rhode Island.

    - Waive certain rules (i.e. requirement that employer contribute at least 60 percent towards family coverage) for a premium assistance program under SCHIP and replace with an overall cost effectiveness test comparing the actual cost in public dollars for the population enrolled in the RIte Share Premium Assistance Program compared to the actual cost in public dollars if that same population was enrolled in RIte Care.

    - Apply the following affordability test/waiting period to SCHIP covered children (ages 8-18 (19^{th} birthday) years old) and 1931 expansion adults with incomes above 110 percent of the FPL (excluding TANF, TANF-related, Extended MA adults, and pregnant women):

        - Six-month waiting period if employee's share of ESI is less than 50% of premium ($150/month for individual coverage and $300/month for family coverage).
        - Six-month waiting period if employee lost coverage as a result of an employer who dropped coverage specifically for a class of employees who would qualify for RIte Care.

    - Apply the following cost sharing for SCHIP enrollees (adults and children) with incomes above 150 percent of the FPL and pregnant women with incomes above 185 percent of the FPL, not to exceed 3% of family income:

        - $25 for non-emergent/non-urgent emergency room visit or for a visit that does not result in an admission
        - $10 Non-generic prescription
        - $5 Generic prescription

- **Amending the Current 1115 Medicaid RIte Care Waiver to:**

- Apply the following affordability tests and waiting periods to 1115 Medicaid waiver expansion infants above 185 percent of the FPL, children ages 1 to 6 with incomes above 133 percent of the FPL and children ages 6 to 8 years old with incomes above 110 percent of the FPL:

    - Six-month waiting period if access to employer-sponsored insurance where employee's share is less than 50% of premium ($150/month individual; $300/month family).
    - Six-month waiting period if employee lost coverage as a result of an employer who dropped coverage specifically for a class of employees who would qualify for RIte Care.

- Apply the following cost sharing for 1115 Medicaid waiver expansion children ages 1 to 8 with incomes above 150 percent of the FPL and 1115 Medicaid waiver expansion infants with incomes above 185 percent of the FPL, not to exceed 3% of family income:

    - $25 for non-emergent/non-urgent ER visit or a visit that does not result in an admission
    - $10 Non-Generic prescription
    - $5 Generic prescription

CHAPTER V
ORGANIZATIONAL AND ADMINISTRATIVE STRUCTURE

A. Current Organization of The Department of Human Services

The proposed demonstration project will be administered within the Center for Child and Family Health, Division of Health Care Quality, Financing and Purchasing, RI Department of Human Services. Exhibit 1 displays the lines of authority within the Department, relative to the demonstration project.

The Department of Human Services is the Single State Agency authorized by HCFA to administer the Medicaid program in Rhode Island. Within the Department, the Division of Health Care Quality, Financing and Purchasing is responsible for the Medicaid program and for assuring the availability of high quality health care services to consumers, assuring the efficiency and economy of services delivered to program recipients by monitoring providers of services, coordinating service-delivery efforts with other State Departments and

Agencies, and administering programs in a manner consistent with federal and state laws and regulations. Services are provided to three population groups: families and children, individuals with disabilities and the elderly.

Within the Division, the Center for Child and Family Health is responsible for program and policy development for all families with children. The Center administers the programs for children with special health needs eligible under SSI, EPSDT or Katie Becket. In addition, the Center administers the RIte Care program, which provides health insurance to families who are eligible for benefits as a result of their eligibility for TANF, who are Medically Needy, or who are income eligible children, pregnant women and parents under Medicaid and SCHIP program expansions targeted at uninsured families.

B. Proposed Demonstration Administration

Except for modifications noted above that the State requests by whatever waivers necessary, RIte Care will remain as it has been with respect to:

- Administration
- Eligibility
- Coverage and benefits
- Delivery systems
- Quality
- Financing
- Systems Support

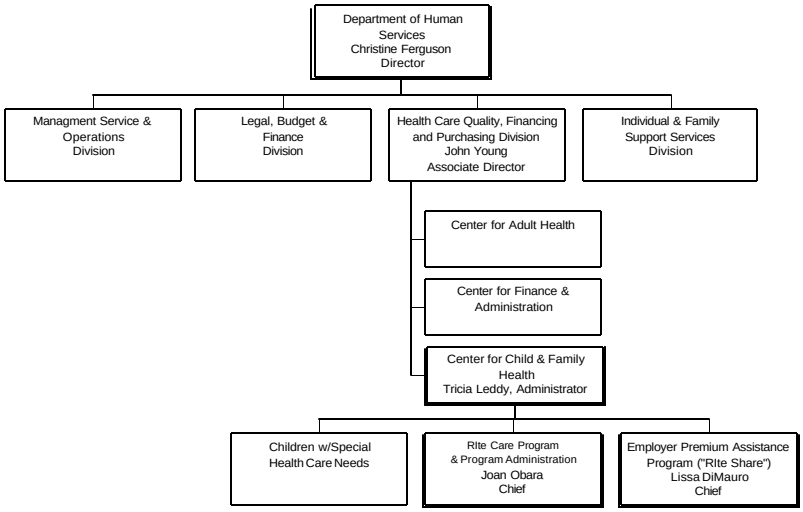
Within the Center for Child and Family Health, staff responsible for administration of the RIte Care Program and the new RIte Share Program will jointly administer the demonstration project. The waiting period, affordability test and the cost-sharing components of the demonstration will apply to both the RIte Care and RIte Share populations, and thus be administered jointly. This joint administration is logical given the State's intent to assure the RIte Share Premium Assistance Program is subject to the same standards for access, quality and performance as RIte Care. It is also the State's intent to use and build on the RIte Care staff and consultant infrastructure for RIte Share in the areas of oversight and monitoring, encounter data collection and analysis, research and evaluation, enrollment and disenrollment, program reporting and financial tracking and accountability.

For timeline and work plan, see *Attachment R.*

Exhibit - 1

Rhode Island Department of Human Services

Administration of Demonstration Program within Current Organizational Structure



C. Community and Business Involvement

The Rhode Island Department of Human Services has already begun to solicit input from the community in its implementation of RIte Share by convening a variety of committees in addition to more formal public comments on regulations. Health Care Reform Rhode Island 2000 mandates the creation of two such formal committees: the Permanent Joint Committee on Health Care Oversight; and the Advisory Commission on Health Care.

The Permanent Joint Committee on Health Care Oversight will consist of eight members of the General Assembly. The purpose of the committee is to monitor, study, report and make recommendations on all areas of health care provision, insurance, liability, licensing, cost and delivery of services, and the adequacy, efficacy and efficiency of statutes, rules, regulations, guidelines, practices, and programs related to health care or health insurance coverage in Rhode Island.

The Advisory Commission on Health Care will be established to advise the Director of the Department on all matters concerning access to affordable, quality care for all Rhode Islanders. The Director will appoint members to this commission in conformance with the specifications outlined in the Health Care Reform Rhode Island 2000.

The Department established the Implementation Planning Group on August 1, 2000, in order to include more immediate and frequent involvement of consumers, advocates and other interested members of the community in advising the Department on the RIte Share implementation process. This group, which is open to the public, is charged with the task of reviewing and commenting on the state plan amendments, regulations, procedures, applications, notices, and consumer information materials related to the implementation of RIte Share. Presently, the group consists of approximately twenty active members and meets on a bi-weekly basis.

To assure employer participation in the RIte Share premium assistance program, the Department has established a Business Advisory Committee. This group is comprised of approximately twelve individuals representing diverse areas within the business sector. The charge of this group will be to assist the Department to maximize employer participation in RIte Share by addressing such issues as ensuring administrative simplicity for participating employers and their eligible employees, ensuring compatibility with the existing employer health insurance programs, and developing strategies for employer and employee education about this program. The Committee's first meeting was October 2, 2000 and two additional meetings have been held since then. The group continues to meet on a bi-weekly basis.

In addition, DHS has established a Health Plan workgroup composed of the three RIte Care Health Plans, which are the only Health Plans licensed to do business in Rhode Island. Its purpose is to collaborate on resolving potential administrative and operational challenges for Health Plans as a result of implementing RIte Share.

The Department is confident the combination of these committees will assure input and representation from diverse aspects of the community.

CHAPTER VI
QUALITY ASSURANCE

The State's expectations under RIte Care for monitoring and oversight are clearly stated in existing contractual arrangements with the Health Plans. It is the State's intention to hold Health Plans to the same standards under RIte Share through an addendum to the RIte Care contract for Health Plans participating in RIte Share as well as in RIte Care. The following is an overview of existing provisions developed to monitor Health Plans.

With respect to oversight and monitoring, the State reviews the performance and practices of the Health Plans in twelve broad categories from administration and marketing to financial management, claims processing and information systems. Each Plan is expected to have administrative procedures capable of identifying and tracking individual members to assure they have access to services included in the basic benefits package.

All Health Plans in Rhode Island are expected to be accredited by National Commission on Quality Assurance (NCQA) that requires Plans to have rigorous quality improvement programs in place. For example, Plans are expected to have a clinical case management system which can identify patients who are most likely to need or utilize enhanced benefits such as smoking cessation, diabetes control, prenatal care, and chronic disease management, such as asthma management.

Systems are necessary for assuring adequate, timely access to referral, specialty and mental health/substance abuse services.

Health Plans are required to submit quarterly encounter data that permits the State to conduct utilization review activities including quarterly monitoring of utilization among various demographic groups to obtain a profile of Plan activities, identify outliers in each Plan and generate corrective actions for improvement. Separate utilization rates are calculated in each demographic group for new and established members (*See Attachment S*). Examples of specific indicators include rate of: new members who are seen by their PCP within 30 days of enrollment; established members in each demographic group who receive the recommended number of preventive visits during the previous 12 months; and PAP smear and family planning utilization among women of child bearing age. Usually, a sufficient range of rates exists from Plan to Plan to generate separate and distinct corrective actions for each health plan. In other instances, program-wide problems are identified that requires a program-focused response in which the State partners with all Plans to make program improvements. The ultimate objective is to collaborate with Plans to improve the services provided to RIte Care members.

Other areas of State oversight and monitoring include grievance and appeal, financial management, claims processing and information systems. The central focus of each of these areas, as well as in the area of quality is to maintain systems capable of monitoring appropriate activity and assuring these systems are integrated into policies and procedures that can identify problems and intervene with appropriate action.

Each Plan is expected to undergo an annual review that follows a systematic protocol to assure compliance with the contract. The State takes special consideration to assure that these reviews are fair, professional and in partnership with the Plans, serve to improve the quality of care provided to clients.

CHAPTER VII

PROGRAM EVALUATION

A. Statement of Goals and Objectives

The primary goals of the RIte Share program are:

1. To improve the health status of Rhode Islanders by improving access to and quality of health care.

2. To reduce the rate of uninsurance in Rhode Island by maximizing Rhode Islander's access to affordable health insurance coverage by leveraging the use of public and private funds.

3. To serve as a pilot program to demonstrate an innovative method for successfully developing and implementing a combined Medicaid and SCHIP premium assistance program.

Goal 1

Objectives:

a) To increase percent of low-income children who utilize age-appropriate preventive care services as a result of being enrolled in family coverage.

b) To expand health care access, improve health status, and promote appropriate utilization of health care services of Rhode Islanders by increasing enrollment in publicly subsidized coverage through implementation of RIte Share.

c) To assess the impact of providing expanded Medicaid benefits on health status, utilization and cost.

d) To promote appropriate utilization of health care services by establishing effective co-payment levels for certain emergency room visits and prescription drugs.

Goal 2

Objectives:

a) To increase total enrollment in public coverage while shifting enrollment from full public coverage (RIte Care) to partially subsidized coverage (RIte Share).

b) To increase the number of low-income children enrolled in health insurance by providing health insurance to their parents.

c) To effectively leverage public funds and employer dollars to reduce the rate of uninsurance by leaving in place dollars used to purchase ESI by: (i) implementing affordability tests and waiting periods to promote retention of ESI; and (ii) maximizing enrollment in RIte Share.

Goal 3

Objectives:

a) To maximize enrollment in RIte Share by simplifying administrative procedures for the clients, Health Plans, employers and the State.

b) To maximize cost savings by waiving certain SCHIP provisions.

B. Summary of Program Evaluation

Rhode Island will determine the effectiveness of the RIte Share including the Premium Assistance Program, affordability tests, waiting periods and cost sharing through a combination of process and outcome evaluation studies. As part of this demonstration waiver the State will conduct the following studies:

Proposed RIte Share Evaluation Studies

Process Evaluation Studies:

1. **Focus Groups** with employers to determine factors that predict employer enrollment in RIte Share and how to recruit and maintain employers in RIte Share. The State will also conduct focus groups with consumers to measure their access and satisfaction with program.
2. **Case Study Analysis** to describe the design and implementation of RIte Share in a "How-to Manual" for other States. This manual will describe the key components of implementing a premium assistance program.

Outcome Evaluation Studies:

1. **Evaluation Reports** using public health data sets to measure and track changes in health care access and health status for Rhode Islanders after implementation of RIte Share. This report will provide baseline health access measures as well as trend changes after implementation of RIte Share.
2. **Satisfaction Survey** with RIte Share employers to determine factors that predict employer enrollment and retention in RIte Share.
3. **Follow-up Survey** of RIte Care and RIte Share applicants who are denied Medical Assistance

benefits due to affordability tests/waiting periods to determine the effect of being denied health benefits on their health insurance status and health status.

4. **Outcome Evaluation Studies** to determine the effect of RIte Care/RIte Share on various outcomes and hypotheses including: the effect of co-payments on pharmacy and emergency department utilization; and impact of expanded Medicaid benefits (medical necessity and behavioral health) on utilization, health status and cost.

C. Review of Research Hypothesis

Both the objectives and the research hypothesis will serve as the basis for the evaluation questions for the RIte Share program. The principal research hypotheses of interest are:

- Does providing health insurance to parents increase the rate of children and families with health insurance and/or increase the rate of appropriate utilization of preventive services?

- What is the impact of being denied public benefits due to affordability tests/waiting periods on health care access and health status of affected families?

- What is the effect of cost sharing including point of service co-payments on pharmacy and emergency room utilization and associated health outcomes?

- What are the factors that maximize enrollment and cost savings in a premium assistance program? What factors determine if a small business chooses to participate in RIte Share?

D. Sources of Data and Analysis Plan

Several data sets that are available at the Department will be used for the analysis of the evaluation. Health indicators from these data sets will be used to track the health outcomes of Rhode Islanders by insurance status. Data sets include existing public health and program data sets. Special evaluation studies will be conducted to answer the research hypotheses. All data sets selected are reliable, well-documented and collect age, sex, race/ethnicity, census tract of residence, insurance status, utilization and health outcomes. The following is a list of the data sets that will be used to create the RIte Share Data Archive (*See Attachment T*):

Existing Statewide Public Health Population Data sets:

1. Hospital Discharge
2. Vital Statistics - Birth Record
3. Behavioral Risk Factor Surveillance System (BRFSS)
4. Rhode Island Health Interview Survey (RIHIS)

RIte Share Program Data sets:

5. Medicaid Management Information System (MMIS)

Special Focused Evaluation Studies:

6. Follow-up study of parents and children who are denied public benefits due to affordability tests/six-month waiting periods.

7. Follow-up study of enrollees to determine effect of cost sharing on access, utilization and quality of care and to determine the effect of insuring parents on their children's health insurance status.

8. Employer survey to determine what factors influence an employers' decision to participate or not participate in RIte Share.

CHAPTER VIII

BUDGET NEUTRALITY

It is the State's expectations that these waivers will be budget neutral. In fact, there should be substantial program savings as the data in *Attachment U* illustrates.

Budget neutrality will be calculated separately for the Medicaid program (RIte Care and RIte Share) and for the SCHIP program. Implementation of the RIte Share Premium Assistance Program as an alternative delivery mechanism for Medicaid will allow the State to maintain budget neutrality, as enrollment in RIte Care or RIte Share will be less costly as compared to the fee-for-service (FFS) equivalency. This is currently required under the Section 1115 waiver of Title XIX and is reported regularly to HCFA by the State.

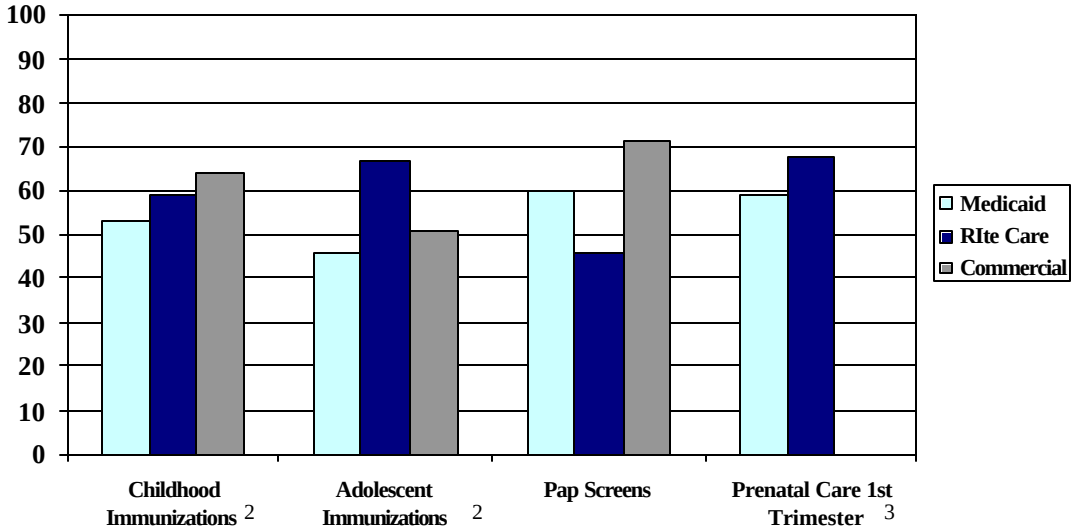
The State will ensure budget neutrality under SCHIP by ensuring the dollars spent under the SCHIP program will not exceed the capped SCHIP allotment levels for Rhode Island.

Conclusion

State policymakers have made it clear that without timely approval of the waivers requested, there will be a roll-back or elimination of eligibility for low-income working parents presently covered under Rhode Island's Section 1931 expansion. If the waivers are approved, the State will be able preserve current eligibility income levels and continue offering coverage to and enrolling uninsured families, in particular those without access to affordable health insurance coverage.

Rhode Island looks forward to HCFA's earliest possible response to these program modifications, as the State intends to implement the premium assistance program on February 1, 2001, and plans to have the new affordability tests, waiting periods and point of service cost sharing provisions in place immediately upon approval, well before February 1, 2001.

Exhibit 1: HEDIS Effectiveness of Care Measures: Comparison of RIte Care Rates with Commercial and National Medicaid Benchmarks [1]



[1] See text for sample characteristics

[2] Proxy measures were used to estimate Childhood Immunization and Adolescent Immunization Rates for RIte Care. See text for detail.

[3] Commercial rates are not available for Prenatal Care begun in 1st Trimester